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Towards the National Health Assembly II

Booklet 2

Health System in India: Crisis & Alternatives

National Coordination Committee,
Jan Swasthya Abhiyan

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NATIONAL COORDINATION COMMITTEE MEMBERS

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- Association for India's Development (AID India)
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- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Voluntary Health Association of India (VHAI)

Participating organisations

Over 1000 organisations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Abhiyan campaign as participating organisations.

About the Jan Swasthya Abhiyan

In 1978 at Alma Ata, the governments of the world came together to sign the Alma Ata Declaration that promised "Health for All by 2000". However this promise was never taken very seriously and was subsequently marginalised in health policy discussions.

As the year 2000 approached it appeared that "Health for All by 2000" was quietly being forgotten by governments around the world. To remind people of this forgotten commitment the First People's Health Assembly was organised in Savar, Bangladesh in December 2000 . The People's Health Assembly was a coming together of people's movements and other non-government civil society organisations all over the world to reiterate the pledge for Health for All and to make governments take this promise seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organisations working to advance the people's health in the context of policies of globalisation.

The national networks and organisations that had come together to organize the National Health Assembly, decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (People's Health Movement). Jan Swasthya Abhiyan forms the Indian regional circle of the global People's Health Movement..

Despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

These trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation - all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug polices as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.

- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.
- It is with this perspective that the organisations constituting the Jan Swasthya Abhiyan have come together to launch a movement, emerging from the Peoples Health Assembly process. Some objectives that this coalition set for itself (which are set out in detail in the Peoples Health Charter) can be listed briefly as below;
- The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalisation on the health of Indian people, especially on the health of the poor.
- The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. This historic commitment needs to be renewed and taken forward, with the slogan 'Health for All - Now!' and in the form of the campaign to establish the Right to Health and Health Care as basic human rights. Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
- In India, globalisation's thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.
- In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care have created considerable wastage of scarce resources and have failed to deliver significant health improvements. The Jan Swasthya Abhiyan seeks to emphasize the urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".

The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems

The Jan Swasthya Abhiyan is being coordinated by National Coordination Committee consisting of 21 major all India networks of peoples movements and NGOs. This is the third book in a six booklet series brought out by the NCC for the NHA II.

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Introduction

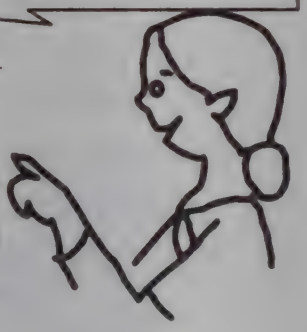
Visit to a Country of Paradoxes

Let us take you on a visit to a large and interesting country. While visiting this country, we are especially interested in understanding the health system prevailing there.

We first see that This Country has Considerable Healthcare Resources

- It has the largest number of medical colleges in the world
- It produces among largest numbers of doctors in the developing world. These doctors are exported to many other countries, and are considered among the best in the world.
- This country gets 'Medical tourists' from many developed countries reflecting the high standard of medical skill and expertise here. They seek care in its state-of-the-art, high-tech hospitals which compare with the best in the world.
- Turning to medicines, we find that this country is the fourth largest producer of drugs by volume in the world and is among the largest exporter of drugs in the world.

Given this situation, what is the health status of the population?



Of course, all these resources require finances. We find that people here do not lag behind in paying and spend a lot on healthcare - more than many other developing countries.

Despite the existence of such impressive healthcare resources, as we begin to move around and talk to some people in the villages and towns of this country we are surprised to find that -

- Despite all these resources, the majority of citizens has very limited access to quality Healthcare, and has poor health indicators.
- There are low levels of immunisation - in fact less than half

of the children are completely immunised (added to this, complete immunisation coverage has declined in recent years!).

- Similarly, the minimum of three checkups during pregnancy remains unavailable for half of all pregnant women.
- There are massive inequities in access to healthcare - while the rich avail of most modern and expensive health services, the poor, especially in rural areas do not get even rudimentary healthcare.
- Hospitalisation rates among the well off are six times higher than rates among the poor!
- Despite such a large drug industry which exports medicines across the globe, about two-thirds of the population lack access to essential drugs.
- This is a country of paradoxes where women from well off families suffer due to unnecessary cesarean operations - in some urban centres close to half of deliveries are done by operation - while their poorer rural sisters frequently die during childbirth due to lack of access to the same cesarean operation at time of genuine need.
- Although people spend a lot on healthcare (the poorest spend one-eighth of their total income on healthcare), the government spends much less. Of the total health spending in the country, all levels of government make less than one-fifth, while the remaining major portion is shelled out by ordinary citizens from their pockets. This makes the healthcare system in this country one of the most privatised systems in the world.
- Taking loans or selling assets pays for two out of five hospitalisation episodes. The proportion of people who are unable to access any form of treatment due to inability to pay is quite large and increasing.

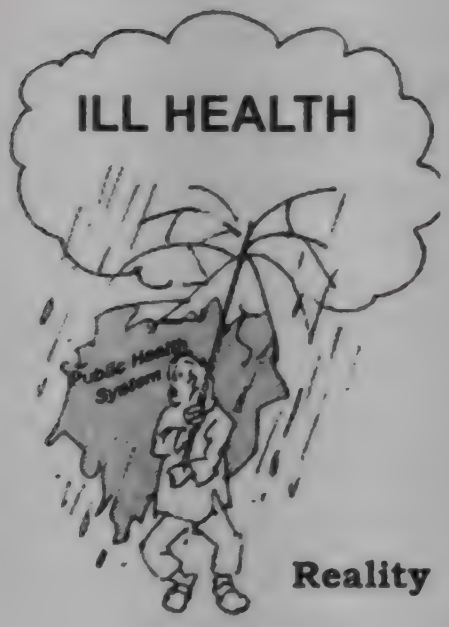
A large private sector leads to high profit motives of private providers. It has been estimated that almost two-thirds of the medicines prescribed here by doctors are irrational or unnecessary. Nearly half of all outpatients receive mostly unnecessary injections.

Hence we say that this is a country of tremendous paradoxes.

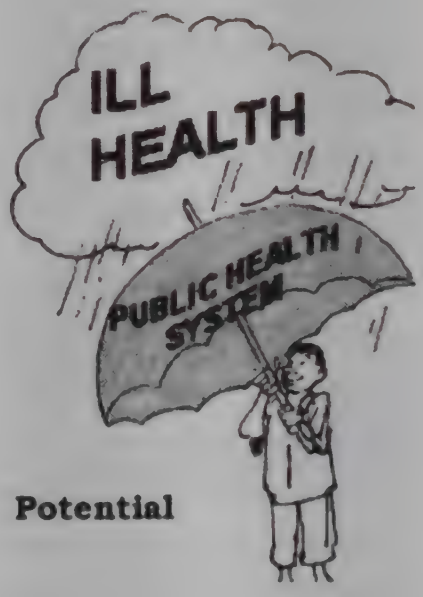
And you must have of course guessed it by now - this is the country where all of us live. This paradoxical country is India, where we have really poor healthcare at high cost, considerable healthcare resources but very poor healthcare access for the majority of people. Let alone the poor, even the middle class cannot easily afford major investigations, hospitalisation and operations. Why we are worse off in this respect even compared to other developing countries? How come the proportion of spending on public health in India is less than even our poor neighbours, Bangladesh and Nepal?

What is the Underlying Problem?

There seems to be something deeply wrong with our entire Healthcare system. It is possible to organise our healthcare system differently, so that today every community, every family and every person in our country can be assured of decent healthcare. Some other developing countries have shown the way, and have made universal access to decent healthcare for their population a reality. Let us try to analyse what is wrong, and suggest a better way of organising the health system in India.



Reality



Potential

Section I

Long Standing Weakness of the Public Health System in India

In India during British rule, state and philanthropic intervention played a significant role in healthcare, though most of these facilities were located in large towns, thus projecting a clear urban bias and neglect of the rural population. Modern medicine gradually undermined systems of Ayurveda and Unani, and those traditional practitioners who survived often concentrated in the small towns and rural areas where modern medicine had not yet penetrated. Despite the Bhore committee's recommendations at the dawn of independence towards correcting the rural-urban imbalance and suggestion of integrated planning for increasing access to health services, even post-independence the weakness of public health services in rural areas and growth of private practice continued. Public health remained a low priority in successive five-year plans and public health efforts remained focused on specific vertical programmes, of which the Family Planning programme was the most prominent. This contributed to the slow and inadequate improvement in health of the population in the period from the 1950s to the 1970s. It may be noted that until 1983 India had no formal health policy; the planning process and various committees appointed from time to time provided most of the inputs for the formulation of health programme design.

This unsatisfactory situation was recognised in the National Health Policy of 1983, which was critical of the curative-oriented western, urban-based model of healthcare, and emphasised a primary healthcare approach. There were recommendations for preventive services and a decentralised system of healthcare, focusing on low expenditure, de-professionalisation (involvement of volunteers and paramedics) and community participation. Although, significant

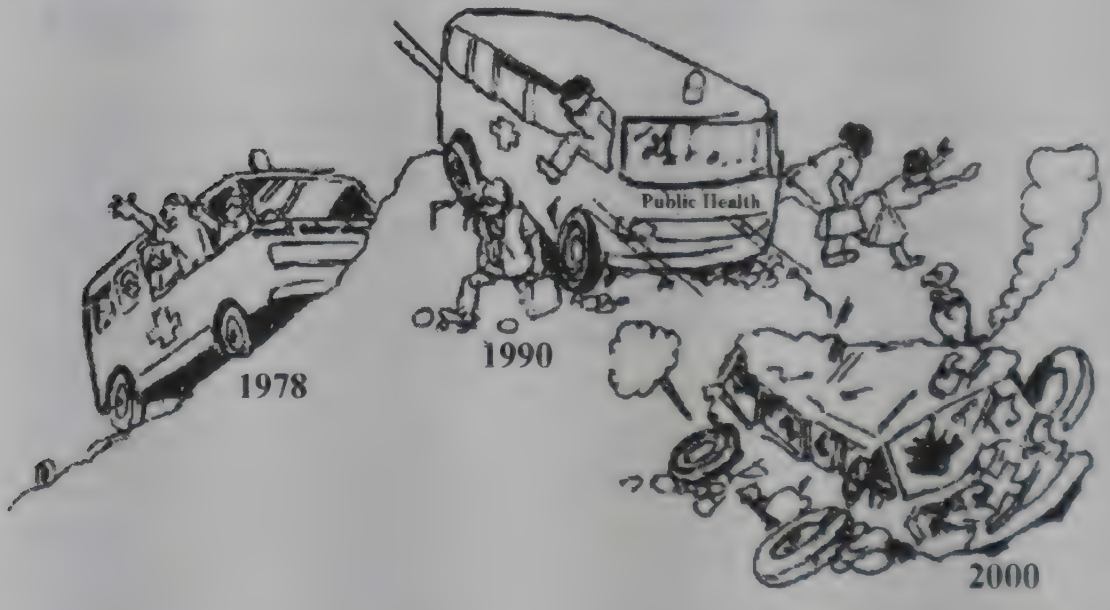
expansion of healthcare infrastructure did take place during the 1980s, this remained grossly underutilised because of poor facilities and low attendance by medical staff, inadequate supplies, insufficient hours, lack of community involvement and lack of proper monitoring mechanisms. The Primary Healthcare Approach was never implemented in its full form, and selective vertical programmes were pushed as a substitute for comprehensive health system development.

This already unsatisfactory situation seriously worsened with the onset of globalisation-liberalisation-privatisation from 1990s onwards. In this situation of inadequate and top-down development of public health, the impact of neo-liberal policies from the 1990s has precipitated the crisis of the public health system; there has been a retreat from even the nominal universal healthcare access objectives. Guided by prescriptions from agencies such as the World Bank, public healthcare has been further constricted to certain 'cost effective' preventive-promotive services and selective interventions, paralleled by spiraling and unregulated expansion of the private medical sector. Introduction of user fees at various levels of public health facilities has also been a feature of the phase since 1990s.

A new National Health Policy was announced in 2002, which

acknowledged that the public healthcare system is grossly deficient on various fronts and resource allocations are generally insufficient. While this policy stated goals like "increase utilisation of public health facilities from current level of less than 20% to more than 75%", no corresponding large-scale measures for rejuvenating and strengthening the debilitated public health system were planned. In fact the 2002 NHP seems like a collection of unconnected statements, a dilution of the role of public health services and an unabashed promotion of the private health sector, including 'medical tourism'.

Thus the phase of privatisation-liberalisation has witnessed staggering health inequities, resurgence of communicable diseases and an even more unregulated drug industry with drug prices shooting up, adding up to the current crisis in public health. Along with the retreat from the goal of universal access, special health needs of women, children and other sections of society with special needs have become further sidelined or are inadequately addressed. A much overdue response to this situation, with certain positive features but beset with its own contradictions, was launched in the form of NRHM in 2005, which is discussed in a separate section below.



To summarise, the objective of universal access to good quality, appropriate healthcare, envisaged over half a century ago at the dawn of Independence, today remains unrealised. Public health has

effectively remained a low priority for the Indian state in terms of financing and political attention. Consequently, there has been a major and growing divergence between the policy rhetoric (such as the Alma Ata Declaration) and actual implementation. Moving in to occupy the hiatus, there has been a massive growth of the private sector, which is unaffordable for a large section of the population, and which lacks any regulation and standardisation.

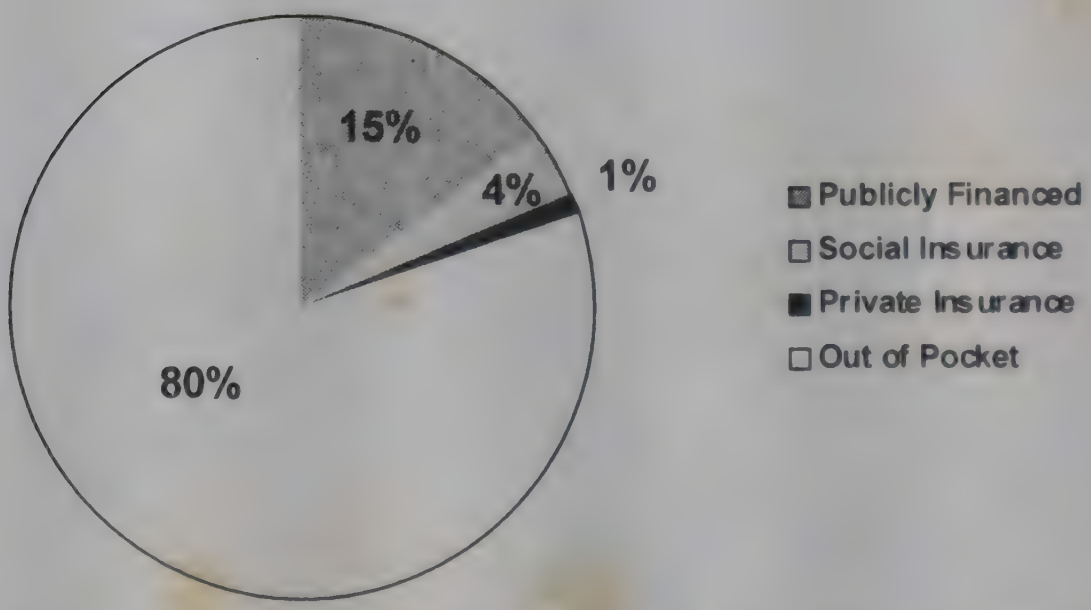
Closely related to this, and compounding this situation has been a Techno-managerial model of healthcare inspired by the West, with an inability to evolve effective indigenous models and appropriate technologies, or to effectively integrate modern and indigenous systems of medicine in contrast to China. The system of Health planning and decision making has remained highly centralised and top-down with minimal accountability, little decentralised planning or scope for genuine community initiatives. A prime example of this is the various communicable disease control programmes that are discussed separately in a later section.

Now, to better understand the lopsided development of the health system, we will first take a look at financing of healthcare in India.

Section II

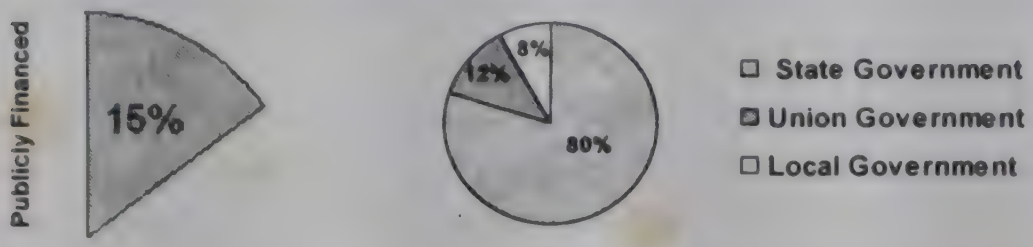
How Much Does Our Government Spend on Healthcare? How Much Do We Spend on Healthcare from Our Personal Resources?

The total value of the health sector in India today is annually over Rs.150, 000 crores or US$ 34 billion. This works out to about Rs.1500 per capita which is 6 per cent of GDP (see Table below). However, of this only 15 per cent is publicly financed, 4 per cent is from social insurance, 1 per cent private insurance and the **remaining 80 per cent is spent out of personal resources.** (85 per cent of which goes to the private sector).



The tragedy is that in India, as in most other countries, those who have the capacity to buy healthcare from the market may often get this care without having to pay for it directly, and those who are below the poverty line are forced to make direct payments to access healthcare from the market.

National data reveals that half of the people in the poorest 20% of population sold assets or took loans to access hospital care. Hence loans and sale of assets are estimated to contribute substantially to financing healthcare. This makes the need for social security even more imminent.



Of the total public health budget today about 10 per cent is externally financed which is in contrast to about 1 per cent prior to the Structural Adjustment loan from the World Bank and loans from other agencies.

A Closer Look at Public Health Spending

Right from the First Five-year Plan onwards, the public health sector has received inadequate resources. Further these resources have largely been focused on the smaller urban-industrial economy. It is clearly evident that the state has over the years committed merely around 3 per cent of public resources for the health sector and this has invariably been less than 1 per cent of GDP. As a consequence the out-of-pocket burden of households has been the main source of financing healthcare.

While overall public health investment and expenditures have been low and inadequate to meet the healthcare needs of the population at large, there are inequities even within this already inadequate public health spending.

An analysis of resource allocation in Maharashtra shows that the rural-urban distribution of resources favours urban health facilities. The rural areas get only half the public resources of what urban areas get on a per capita basis, and within this low allocation only 4

per cent is for medical care and a little over one percent for capital expenditures. The rest is on preventive and promotive programmes. In contrast in the urban areas it is a somewhat better mix of curative, preventive and promotive services, with curative services comprising nearly half the urban health budget. While this data is from Maharashtra, in other states the rural-urban differences should not be very different.

In recent years, one can see deterioration in healthcare access in most parts of the country because of reduced public investments and expenditures, which is compelling people to increasingly access healthcare from the private sector which is expanding rapidly. Prime public health services have come under the purview of privatisation and user fees have been introduced across the board with the consequence that large numbers of the poor who were the main users of these services have now moved away from them.

The collapse of the public health system during the last one-and a half decades is definitely linked to the falling levels of public health investment and the declining public health expenditures, accompanied by increased privatisation of healthcare.

Section III

Is Deterioration of the Public Health System Linked with Expansion of the Private Medical Sector?

India has always had a large private sector, which includes both providers of modern medicine and traditional practitioners. During the 1980s, public health spending peaked at around 1.5% of GDP and this was reflected in health infrastructure expansion in rural India via the Minimum Needs Program.

However, from the nineties onward the public health sector was woefully neglected with new public investments being virtually stopped and expenditures as a proportion of GDP declining, as reflected in the table below. During the same period the private health sector, including the hospital sector has expanded rapidly. Simultaneously even the public health system was being reformed to fit the private model, through introduction of user charges and contracting out of services. It would not be wrong to say that in the health system, the private health sector has now become completely dominant and is

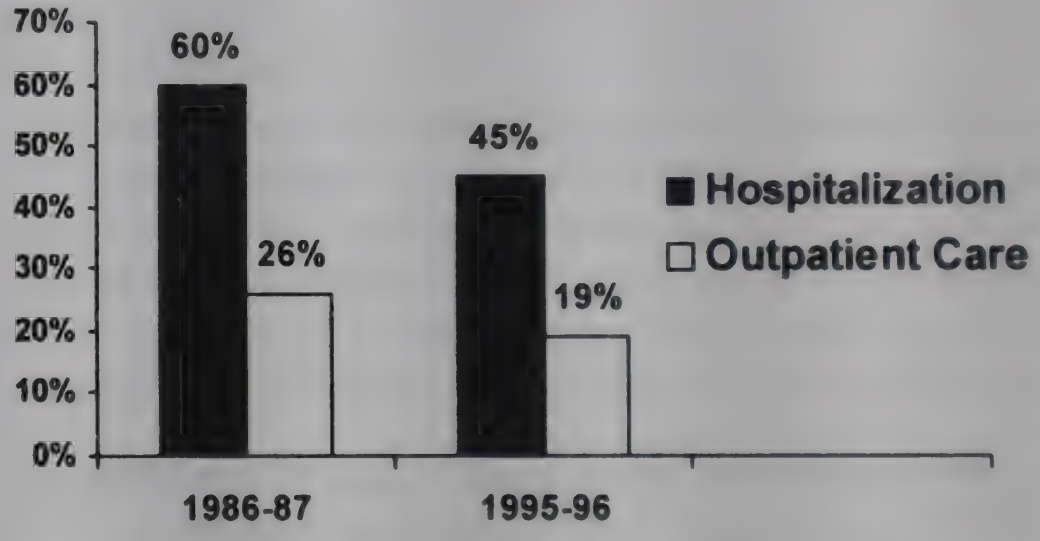
Health Expenditures in India as a ratio to Gross Domestic Product (GDP) at current prices 1980 - 2005 and Hospitals and Beds in the Private Sector

	1980 81	1985 86	1991 92	1995 96	1998 99	2000 01	2004-05 (BE)
Public							
%GDP	1.07	1.32	0.88	0.86	0.91	0.81	0.83
Private							
%GDP	3.88	3.45	2.60	2.94	4.09	4.46	4.67
% Hospitals	43		57	68		76	
% Beds	28		32	37		55	

either replacing or reshaping the public sector in its own image.

Why is the Shift to the Private Sector an Issue of Concern?

As noted above, during the nineties the public health system was collapsing due to under-financing of public health services. The structural adjustment and economic reforms program which began in 1992 after the 1991-92 fiscal crises further shrunk resource allocations for public health services. Further, the introduction of user fees struck the final blow for the poor who are the vast majority of users of public health facilities. This is evident from national health surveys that clearly indicate declining use of public health resources.



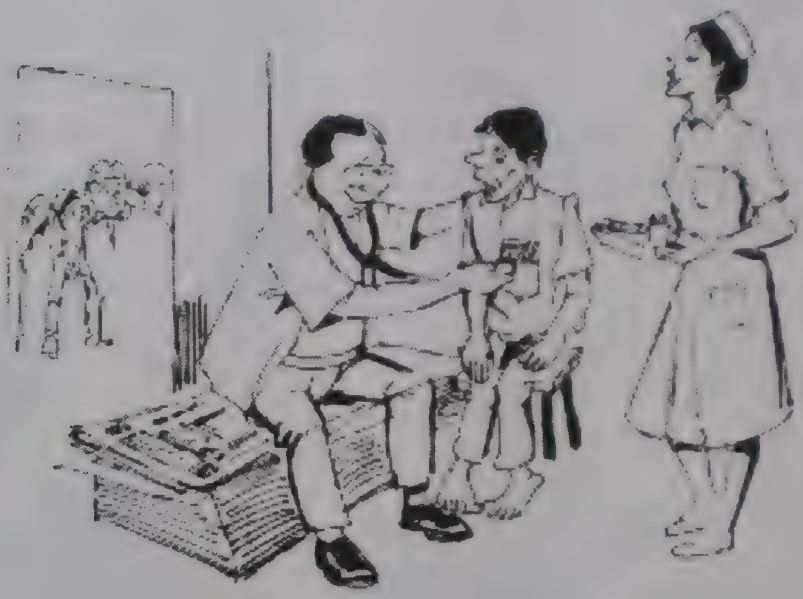
Decline in Hospitalisation and Outpatient Care in the Public Health System

The same health surveys also reveal that the rate of hospitalisation as reported in the survey have very strong class gradients with the top 20% of the population reporting over six times higher hospitalisation rates than the poorest 20%. The changed political economy of medical care with overwhelming dominance of the private sector has decimated the public healthcare sector, with the brunt of the

consequent deprivation being borne by the poorer sections of the population. The increasing market dependence to seek healthcare makes the poor postpone and forgo attention for medical care. This situation has not only helped the private health sector to consolidate its position, it is also now in a position to manoeuvre for privatisation of public health facilities.

In India privatisation of healthcare is taking various forms - from disinvestment (hospitals and health centres are being handed over on outright purchase and/or long term leases), to lease contracts, to contracting out of services (laundry, diet, diagnostic services, pharmaceutical supplies, private consulting facilities etc.), to introduction of user fees (user charges for various services in dispensaries and hospitals). And of course by plain default, with public provision being neglected, the private sector moves in to fill the gap. This increased private control and marketisation of healthcare is not only making access to healthcare for the poor more difficult but also given the complete absence of any regulation of private healthcare and lack of ethical conduct of professionals, it is making healthcare just like any other commercial commodity. The pharmaceutical industry is a major engine of such growth patterns, since the Indian pharmaceutical companies are global players and even multinational

companies (MNCs) in their own right. Private health insurance too is waiting on the sidelines although it is presently somewhat hesitant to enter the market in a full-fledged manner because of its highly unregulated nature.



Section IV

The Private Medical Sector - The Camel Which Pushed the Arab Out of the Tent

India has the largest private medical sector in the world. Private medical practice flourishes almost everywhere. The range of providers are also varied, from the herbal healer to the modern unqualified or quasi-qualified 'quack', and to the qualified practitioners of different systems of medicine, many of whom also regularly indulge in irrational practices.

Although there is no firm data available on the entire range of practitioners, we know that today there are about 14 lakh practitioners (1 per 715 population) registered with councils of various systems of medicine in the country. Of these only 1.6 lakh are in government service. This leaves 12.4 lakh doctors of various systems of medicine in the private sector and one can safely assume that at least 80% of them (about 10 lakh) are economically active. Apart from this there may be a comparable number of unqualified practitioners according to an estimate based on a study done by UNICEF/ SRI-IMRB in Uttar Pradesh.

However, the nature of the private sector itself has changed a lot in the last few decades -

- Until the mid-seventies, hospital services were predominantly in the public domain. Within the private health sector, large hospitals were mostly in the not-for-profit or charitable sector. The for-profit private hospitals were primarily small nursing homes.
- However the large growth in numbers of specialists post 1975 changed the scenario completely, and by the mid eighties the for-profit private hospitals became a force to reckon with. Post mid-seventies the State also provided various incentives like concessional land, tax-breaks and duty exemptions for

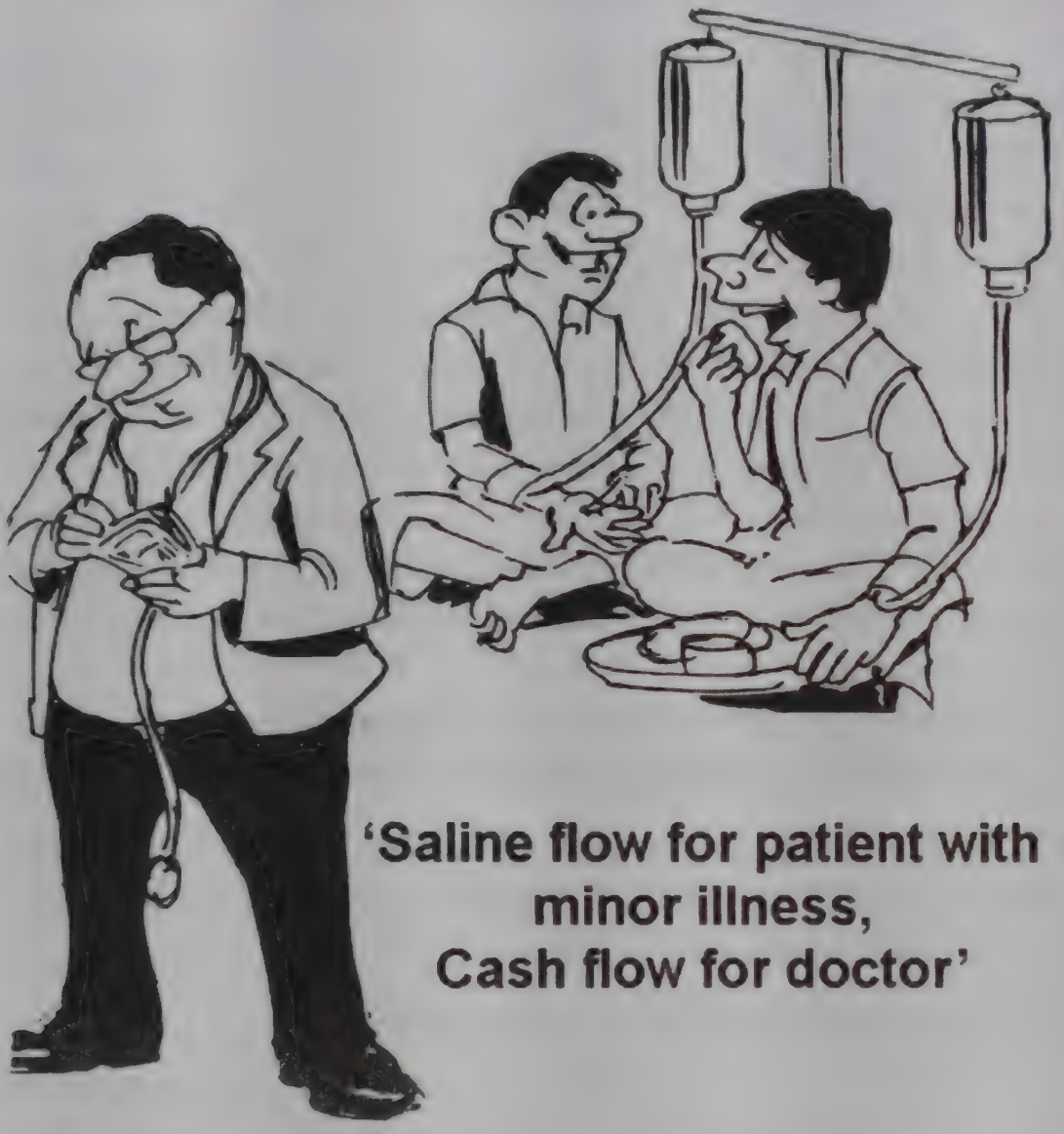
imports for setting up of private hospitals. The private pharmaceutical industry received substantial State-patronage for its growth through process patent laws, subsidised bulk drugs from public sector companies and protection from MNCs.

- By 1990s the corporate sector had recognised the new emerging opportunities in private healthcare, and with the rapid changes in medical technology it came forward to invest in a big way in expanding the private hospital sector. Medical education was almost a public monopoly until late 1980s after which the private sector grew rapidly, but even today 75% of

turnout of medical graduates is from public medical schools. In fact, as part of the larger paradox, the public medical schools contributed significantly to the growth of the private sector since on an average 80% of the medical graduates entered private practice or migrated abroad.

These changes have not been in a vacuum, but were an integral part of the processes unleashed by the structural adjustment reforms.

If we consider the Public Health System to be the 'Arab' in the story, who initially allowed the 'camel' (Private Medical Sector) to put its neck in the tent, then it is obvious that now the 'Arab' is out in the cold and the 'camel' has occupied the entire tent! Under the name of 'reforms' the state stopped major new investments in the hospital sector leaving the field open for private investment to take over. Not only that, the government offered major concessions and subsidies



to the private hospitals in the form of free or very cheap land, tax holidays, rebates in customs tariffs, low interest loans from public sector banks, handing over of public hospitals fully or partly to private entities etc. As if this was not enough, these for-profit hospitals which

have low bed occupancies as of now get further support from the state in the form of patients from amongst government employees, for which the government reimburses these hospitals at market rates, thus helping secure their profit margins. Today many of these elite private hospitals have become global institutions catering to healthcare needs of patients from across the world. To support their survival the private health insurance sector is being encouraged and the latter is presently growing at over 30% per annum.

While the private medical sector has become a huge giant it operates in a much-unregulated manner. There exists no significant regulation and specification of standards of care for the private medical sector and since it is now the dominant player, the absence of regulation is very risky for its clients. Hence the private health sector has to be reined in through comprehensive regulation, which needs to be facilitated through the legal route. Regulation will help bring about accountability and improved quality of care. We should also consider bringing a quality and cost regulated private medical sector under the public umbrella. The public system could harness such providers to provide services free of cost to consumers, which would complement a significantly strengthened public health system.

What should be Included in a Comprehensive Regulatory Framework for the Private Medical Sector?

The following suggestions on regulation encompass the entire private health sector. This is not an exhaustive list but only some important areas needing regulation.

1. Private Nursing Homes and Hospitals

- Setting up minimum standards and requirements for each type of unit - general specifications for general hospitals and nursing homes and special requirements for specialist care, example maternity homes, cardiac units, intensive care units etc. This should include physical standards of space requirements and hygiene, equipment requirements, human power requirements

(adequate nurse: doctor and doctor: beds ratios) and their proper qualifications etc.

- Maintenance of proper medical and other records that should be made available statutorily to patients and on demand to inspecting authorities.
- Setting up of a strict referral system for hospitalisation and secondary and tertiary care
- Fixing reasonable and standard hospital, professional and service charges.
- Filing of basic data returns to the appropriate authorities for example data on notifiable diseases, detailed death and birth records, patient and treatment data, financial returns
- Regular medical and prescription audits which must be reported to the appropriate authority
- Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements
- Periodical renewal of registration after a thorough audit of the facility
- Tripartite monitoring and appellate bodies to oversee regulation, involving representatives of government, consumer organisations and health groups, and doctors' representatives

2. Private Practitioners

- Ensuring that practitioners are allowed to practice as per their qualifications
- Compulsory maintenance of patient records, including prescriptions, with regular audit by concerned authorities
- Fixing of standard reasonable charges for fees and services
- Regulating proper geographical distribution, promoting greater equity in access
- Filing appropriate data returns about patients and their treatment
- Provision for continuing medical education on a periodic basis with renewal of licence being made dependent on its completion

3. Diagnostic Facilities

- Ensuring basic quality standards and qualified personnel
- Standard reasonable charges for various diagnostic tests and procedures
- Audit of tests and procedures to check their unnecessary use
- Proper geographical distribution to prevent over concentration in certain large urban centres

4. Pharmacies

- Formulation of a National Formulary of Generic Drugs, which must be used for prescribing by doctors and hospitals
- Ensuring that pharmacies undergo regular inspection by authorities
- Pharmacies should accept only generic drug prescriptions and must retain a copy of the prescription for audit purposes.

Section V

Brain Drain, Medical Tourism and Outsourcing

Brain Drain

Right from early 1950s, India's Five Year Plans focused on two key areas of the health sector - medical human power and pharmaceutical production. In both these sectors the State played a direct role. Medical Colleges were almost entirely state run and medical education was virtually free, and each Five Year Plan right through until the eighties was doubling production of doctors until it stabilised around 15,000 doctors per annum. Similarly in drug production the State was a key manufacturer of bulk drugs and provided a patent regime of process patenting which permitted the fledgling Indian drug industry to compete with global transnational corporations. By mid-eighties Indian pharmaceutical industry had come of age and was ready to take on the world. But India's healthcare, both public and private sector, remained elitist and the vast majority of the country's population did not have adequate access to good quality healthcare, especially the 70% population that lives in villages. Just as the doctors tended to remain concentrated in the large urban centres within the country, a portion of doctors especially with specialised skills migrated to the developed countries.

The brain drain of doctors, which had taken place right from the 1950's onwards, can be blamed for lack of a robust health system within the country that would have

retained them, linked with poor access to quality healthcare for the rural population.

- During the First 5 Year Plan (1952-1957) one-third of doctors produced migrated to developed countries like UK, Canada, USA and other European countries.
- This trend of out-migration of doctors ranging between 30% and 40% continued until 1990 with an average of over 5000 doctors migrating each year.
- The most astonishing example is that of the elite All India Institute of Medical Sciences, created by the Indian Parliament as an institution of national excellence, from where between 1956 and 1980, fifty six percent of its medical graduates left the country for greener pastures.
- This trend has continued through the nineties and into the new Millennium, though one is also witnessing in recent years a return of experienced doctors as India increasingly integrates with the world economy.
- A recent study of the major recipient countries of USA, Canada, UK and Australia, shows that India leads in the number of physicians it has supplied to these countries, as many as 59,523 physicians of Indian origin working in these four countries followed by Philippines a distant second contributing 18,303 physicians. This brain drain has considerably weakened the healthcare systems of the supplier countries, especially those from Africa and the Caribbean.
- India's loss works out to over $170 million per year for an average of 5000 doctors leaving the country each year and this is over 3% of the national public health budget. But the larger impact of this loss is that 55% of physician positions in rural hospitals and 30% in Primary Health Centres are vacant and this has caused a catastrophic harm to the public health system in India.

Public Subsidy to Private Hospitals

Post economic-reforms of the 1990's investment in private healthcare

began to increase by leaps and bounds. In 1992-93 the private health sector accounted for 2.5% of GDP and in 2004-05 it is estimated at 5.6% of GDP. During the same period public health spending increased marginally from 0.74% to 0.92% of GDP but it was much lower than the 1.5% of GDP it had peaked in 1986. The engine of private sector's growth was threefold. First India's pharmaceutical industry had acquired a transnational character accounting for 8% of world drug production by volume and exporting 52% of total domestic production. Second, medical education was opened up to the private sector and within a decade medical colleges increased from 102 in the early nineties to 190 today increasing out-turns of medical graduates to about 19,000 from 15,000. And third, the private hospital sector came of age with corporate houses entering with huge investments to set up world-class hospitals and many of the earlier not-for-profit (Trust owned) hospitals also joined the bandwagon to create elite hospitals. Out of the 18,000 hospitals in India, 500 to 600 would be such elite hospitals having average bed strength of 200 and an indoor annual patient load of about 8000. It is this small, elite class of hospitals that are seeking a share in the global market under the garb of medical tourism- and these hospitals are able to prosper due to the public subsidies that they receive.

Let us illustrate this with an example of one of the best-known hospitals from India, the Apollo Hospital in Delhi.

Apollo Hospital Group prides itself as being the "the fourth largest private healthcare group in the world and the largest in Asia. With over 6400 beds in 32 hospitals, a string of nursing and hospital management colleges, and dual lifelines of pharmacies and diagnostic clinics" it is indeed a "powerhouse" of healthcare. The Indraprastha Apollo Hospital, New Delhi is the fourth largest corporate owned hospital in the world constructed at a cost of $ 44 million which has 692 beds and 14 operation theatres and handles about 200,000 patients annually, about 60,000 being indoor patients and of the latter about 10,000 or 17% are from other countries. This hospital was built in 1996 on 15 acres prime land worth an estimated $2.5 million given

by the Delhi government free of cost (at a token lease rent of Re 1 per annum). Apart from this the Delhi government invested $3.4 million in construction of the hospital and contributed $5.22 million as equity capital. Besides this tax and duty waivers on import of equipment etc. were also given. In lieu of this public subsidy the agreement was that treatment for one-third of the beds would be made available free of cost to poor patients.

The fact of the matter is that the free treatment part was undermined by the Hospital, both a legal and ethical violation, and the Delhi government was negligent in demanding accountability to honour the terms of the agreement. When this fact came to public notice public interest litigation was filed in the Delhi High Court and this led to the appointment of the Justice Qureshi Committee, which exposed the huge scam of misuse of public subsidies by private hospitals in Delhi, including the Apollo Hospital case (also discussed in next section). The Report further indicated that only 2% of indoor cases in 1999-2000 in Apollo Hospital were treated free and most of these were relatives of staff, bureaucrats and politicians. In contrast

the average for all the 27 hospitals was 9.7% free indoor patients.

There are at least 500 such hospitals across the country and the public subsidy at stake would be in the range of at least ten thousand crore rupees! And it is these very hospitals, which are at the core of the booming medical tourism.

Medical Tourism or Brain Drain Plus

Medical tourism may be viewed as a parallel kind of Business Process Outsourcing (BPO); In fact Medical tourism is a continuum of the brain drain of the bygone era. The new knowledge economy has created possibilities where transfer of knowledge and skills does not require physical migration. And it is this, which has facilitated the BPO revolution, and medical tourism is a part and parcel of that. In the earlier period, we witnessed the phenomenon of brain drain. This entailed loss of a skilled person who, instead of working in his / her home country, was contributing to the recipient country's economy and sent some remittance back home. The new incarnation in the form of medical tourism can be called **brain drain plus**. This requires the skilled person to stay back within the country, get wages marginally higher than what s/he would get working for a local company, use infrastructure and other resources from his/her own country, cause environment damage within one's own country, and contribute a much higher surplus (including the difference between the wages paid in the developed country and the developing country) to the developed country economy.

Medical tourism would precisely do the same thing. The doctors are trained within the country using largely public resources, the investment and capital for hospitals and related healthcare facilities comes from within the country, there are large amounts of public subsidy in private healthcare as we have seen above, the supportive infrastructure used is from the host country, the waste generated in the process is dumped within the host country and pollutes the host country environment etc. and their skills are used increasingly to provide services to those from more affluent countries. And all this

Private Medical Insurance

Private or what is often also called "voluntary" insurance is a recent phenomenon starting in an organised way some time in the mid eighties through the public sector insurance companies. Prior to that these insurance companies did have group insurance schemes, for their special clients (i.e. big general insurance clients) but that covered an insignificant number of employees and their families. From mid eighties the Mediclaim scheme, which is an individual hospitalisation policy and does not cover comprehensive healthcare was started. This picked up momentum gradually and entered the growth phase around 1998 but even today covers just over one percent of the population. The public sector insurance companies gross annual premiums of Rs.1000 crores for Mediclaim policies from 1 crore insured lives. In the last few years some private insurance companies have also entered the fray but they are as yet very small players having less than 10% of the market share. Insurance persons predict that Mediclaim is slated to touch 5 crore persons in the next two years with the rapidly escalating cost of private healthcare as also extension of user fees in public hospitals. The private insurance companies are also slated to capture an increased market share in this business. This includes efforts at getting mass premiums through governments for insuring population of entire state or selected groups of population. Assam is a well-known case where in July 2005 ICICI sold a policy with premiums worth Rs 25 crores and now a year later it turns out that the claims ratio is barely 20%. Thus ICICI has made a huge profit in a situation where people lacked information about the policy; those who did know became victims of bureaucratic procedures or exclusions being brought up in fine print. The state negotiated the ...

is done to provide healthcare at ten times less cost than the developed country for the benefit of the person from the developed country. At present the medical tourists we get in India, estimated at around 150,000 annually come on a voluntary basis and contribute an estimated $750 million annually to India's hospital and allied sector. Just imagine if UK's NHS or health establishments or insurance companies from Canada, USA, Australia and other European countries enter into organised contracts with hospitals or even governments in India and other developing countries then what will happen to healthcare in these countries and especially for the vast

Private Medical Insurance contd...

...policy knowing well that Assam lacks the infrastructure to provide access to healthcare for its people both in the public and private sector. This example has every chance of being repeated in other states in the name of universal insurance, wasting precious public resources to secure bottom lines of private insurance companies. No country in the world has achieved universal health insurance via private insurance. Rather it has been through publicly subsidised and managed social insurance or national insurance, which has a compulsory element for contributions from earners and the State contributing for those who do not earn or earn too little to make a contribution. Private insurance can never be the route for universal insurance and state governments should be wary of making such deals under the universal health insurance scheme designed by the central government.

Further there are a number of small initiatives, now fairly well documented also, of NGOs and community based organisations, including credit and thrift groups using collective mechanisms of financing including insurance, mutual funds, prepayment schemes and managed care kind of financing and provision of care, cooperatives (Yeshaswini in Karnataka), unions (SEWA in Gujarat) etc. and sometimes even donor financed. However these are very sporadic instances, though presently widely discussed as the most appropriate option for India's poor, especially rural and unorganised sector population. A close analysis of these schemes shows that they are mostly successful as long as there is a subsidy available from donors or government, or even linked to livelihood or savings schemes. In the absence of subsidy they are often doomed to failure.

majority of the poor and lower middle classes.

In this era of globalisation, for a profit motivated global capital, exploiting opportunities in areas having low price and high quality is a linked development. From a developing country's perspective, this might appear to be attractive for some, to widen business opportunities as well to earn foreign exchange. But socially and politically there is a major problem with supporting such a strategy because we already have a very large number of people with very poor access to healthcare.

Corporate hospitals are not new in India; only their form is new.

The earlier version of hospitals supported by business community were of two kinds, one genuinely charitable in nature (many of which over time became public hospitals with state support) and another which took the garb of charity to create hospitals which were basically for the elite, that is hospitals registered as trusts but not complying with provisions of the trust act, and supported by a state (the charity commission) which looked the other way. The Apollo Hospital case mentioned earlier belongs to this genre. As in the case of Apollo, these hospitals take the tax shelter but do not comply with obligations under it to treat the poor. They use the crutch of the state to obtain subsidies like free or cheap land, capital investment by the state, assured clientele from state agencies etc. Yet still they have vacant capacity because the prices they charge are exorbitant, which the local market cannot absorb. Health insurance, which is the only way the middle class could comfortably pay for such rates, is still in its infancy in India. Hence from the commercial perspective the corporates are looking at global markets to promote medical tourism.

Healthcare in India, including corporate hospitals, is not regulated from the perspective of their being healthcare providers but perhaps only as businesses. If these corporate hospitals have received subsidies in any form from the state then they are obligated to provide free care to the poor in a defined proportion of their total patients, as agreed to by contract. If they are Trust owned, then they should provide care to the poor as per the Public Trust Act mandate. But this does not actually take place because of lack of monitoring, audit and accountability. We have seen above the case of Apollo Hospital, which was investigated by the Justice Qureshi Committee appointed by the Delhi High Court. Given this context, it should be sharply questioned whether the state (especially of a developing country which has three-fourths of its population either poor or living at subsistence) should collaborate in promoting medical care for tourists when it cannot meet the basic healthcare needs of the majority of its citizens. We feel that the state should stay away from such participation or support, and must focus its energies on assuring basic healthcare as a right to its citizens. There is no economic, social or political justification compulsion to provide state support to medical tourism.

Section VI

NRHM - Health System Restructuring but in which Direction?

NRHM is the flagship program of the UPA government in the health sector. The preamble of the NRHM document states - "The Goal of the Mission is to improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women and children." This goal is to be achieved by strengthening the three levels of rural healthcare - the sub centre, PHC and CHC. At the village/hamlet level a health worker called ASHA (Accredited Social Health Activist) will be appointed who will be the link worker for rest of the public health system in rural areas. Additional resource allocation and up gradation of the facilities at each level has been planned under the Mission.

However the NRHM needs to be seen as a programme for health system restructuring in the era of liberalisation-privatisation, which continues many of the policy flaws of earlier periods. The mission begins with the statement; "The NRHM seeks to provide effective healthcare to the poor, the vulnerable and to marginalise sections of society throughout the country". One acknowledges that these groups need special support from the public health system but the goal of the program cannot remain selective because in doing so it distorts the design. It is well established today that anything designed specifically for the poor or marginalised does not work in practice. If universal access is not at the core of the mission design then its fate will not be very different from all the health programs we have witnessed hitherto.

Jan Swasthya Abhiyan has already published a detailed analysis of the NRHM framework in the form of an 'Action Alert', which deals with various components of the Mission, in considerable detail. Here we would only take an overview of the main trends within the Mission, without dealing with each of its specific components

NRHM: Contending Models of Restructuring

The recent launching of the National Rural Health Mission is an official response to the widely recognised crisis of the public health system in India. There is a positive, though belated, recognition of the fact that the prevailing state of affairs related to public health services, especially in rural areas, cannot continue any longer in the same manner as it has during the last one and half decades. The restructuring (called 'architectural correction' in Mission documents) of the Indian health system has now been taken on the agenda. The Mission opens the path for structural change, signifying that we are entering a transitional period, where it can no longer be 'business as usual' for Public health in India.

However, the depth and primary direction of this restructuring is still unfolding, and as of yet is a matter of contention. Let us examine the major strands in this restructuring process.

Public Health System Strengthening and Internal Reforms

There appears to be a large area of general agreement, which occupies the 'middle ground' in thinking about the Mission: the need for greater public investments in health, more funds from the Centre to states, construction of more buildings, stronger public management etc. There seems to be a degree of unanimity that public health must be given higher political priority, and that greater resources should become available, which are essential for strengthening public health in India today. However, limiting the Mission to such resource strengthening and some administrative rearrangements (which may be the de facto thinking in some official quarters) would amount to 'more business as usual'.

Fortunately, it has also been recognised that increased public resources need to be combined with definitive forms of systemic restructuring to make the structures much more effective and accountable. Concerning restructuring, there is a set of changes that

may be termed as 'Public Health System Internal Reforms' which envisages certain organisational and management changes within the system. These include giving certain degree of autonomy in decision making to public health institutions, making available untied funds at various levels, allowing greater flexibility in decision making, improving transparency and introducing more efficient mechanisms such as for drug procurement and distribution, introducing rational treatment protocols etc. At the state level, the SHRC Chhattisgarh has initiated certain such health sector reforms at the state level, the Karnataka task force on Health has recommended a range of policy measures, and states like Tamil Nadu have introduced mechanisms for drug procurement and distribution. These kinds of reforms, which often reduce bureaucratism and over-centralisation, and increase autonomy and flexibility at various levels of the Public Health System, are of course extremely necessary and need to be actively implemented; it is not likely that there would be major objection to implementing such measures.

However, in addition to these internal reforms, there is *the issue of introduction of qualitatively new forms of interaction and introducing new forces into the system.* Here, on either side of the 'middle ground', there are two different streams, which seek major changes in the existing structure. Throughout the Mission documents, one can clearly see a tension between these two contending models of restructuring. Sometimes it may not even be noticed that two streams with differing assumptions and goals exist within the same discourse. However, there is a crucial difference, which lies in identifying the 'critical direction' and the propelling force for the desired change. It will be worthwhile to recognise these contending currents, so that at least whatever choices are made, they are made consciously and deliberately.

Privatisation and Semi-Privatisation

One stream for qualitative restructuring (which is likely to dominate over the other stream) looks towards various forms of privatisation-oriented measures to rejuvenate public health institutions, and

partnerships with the private sector as the desirable direction for change. This stream is most strongly reflected in recent NRHM documents on 'Rogi Kalyan Samitis' (RKS) and 'Public - Private Partnerships'. Overall the solution to bureaucratism and non-responsive services is sought in the document on RKS by making public hospitals into autonomous societies which would charge user fees, can contract out services and may share resources with the private medical sector. Such measures are considered to be the way forward for restructuring public health institutions. Similarly, a number of (though not all) forms of 'Public - Private Partnerships' proposed in the recent document on this hardly emphasis strong public regulation of the private sector, and certain measures seem to dilute public responsibility by putting a stamp on activities being carried out by a private sector, regulated weakly if at all. Regarding the role of NGOs, this stream views *NGOs primarily as one more form of private implementing institution, sub-contractors which can provide services in a cheaper and more effective manner, and not as social mobilisers and agents for community accountability.*

Community Accountability and Empowerment

The other stream of qualitative restructuring is reflected in a weaker (more symbolic than substantive) form in Mission documents, but exists and influences the Mission nevertheless. This stream, which is broadly supported by the diverse health movement in the country, emphasises the need to bring the public centre-stage in the Public health system: for strong community-oriented accountability structures, definite health rights and public health standards, and clear devolution of powers with decentralised decision making mechanisms, emphasising involvement of communities and panchayat representatives. This form of thinking is mentioned throughout various Mission documents, but often in a diluted and ritualistic form, rather than by defining clear processes, mechanisms and budgetary provisions to actually transfer power to communities, their organisations and representatives. In this stream, the role of NGOs would be not that of sub-contractors (though they might contribute to specific forms

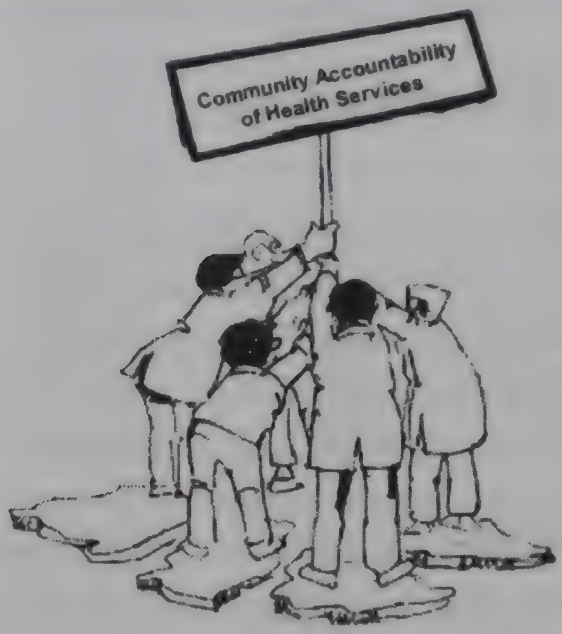
of implementation), but primarily as allies of communities and community-based organisations, strengthening the much-needed movement for accountability of the public health system. The framework of *Community-based monitoring* in the NRHM framework document, which proposes participatory monitoring and planning committees at all levels from village to state provides a potential space to push such processes for accountability- however these potentials can be actualised only through a movement of active and sustained intervention by pro-people organisations and communities.

Public-Private Partnership or Public-People Partnership?

Either of these two kinds of qualitative restructuring could realistically be combined with internal reforms and de-bureaucratisation of the Public health system, mentioned towards the beginning of this section. Thus we could have a package of internal public system reforms + semi-privatisation or a package of internal public system reforms + devolving powers to communities. In the further discussion, a package of reforms focused on privatisation oriented measures will be called the 'Semi-privatisation' option while a package of reforms focused on community control will be called the 'Communitisation' option.

This distinction does not ignore the fact that both forms of thinking (privatisation oriented and community control oriented) may sometimes, be combined even in the same NRHM document. It also does not gloss over the fact that today private healthcare is the dominant form of service provision, and a realistic and appropriate role for the private sector must be defined in the context of the public health system. It also should not be assumed that 'communitisation of health services' will solve all problems, or that it would be a simple or straightforward task. However, it must be recognised that the underlying values, assumptions and long-term vision of Semi-privatisation and Communitisation are fundamentally different. It is worth noting that wherever genuine community control has been strengthened through structural changes (such as during the

phase of decentralisation in Kerala in 1996-2001, or in Nagaland as part of the Communitisation process) privatisation has generally taken a back seat. In fact in Nagaland, private practitioners have begun referring patients to PHCs! And wherever semi-privatisation has been pushed in a major way (such as the health sector reforms under the previous govt. in Andhra Pradesh), the cause of community control has been significantly weakened; in fact there have been negative popular reactions.



The current balance of forces at the national level is more likely to serve the cause of semi-privatisation, since the dominant official style of thinking at all levels, from international to local, is much more sympathetic to private actors than to organised communities, and private agencies in the health sector are often far stronger than community interests. A certain variety of 'market fundamentalism' currently strongly influences official thinking, according to which, independent of the actual evidence, it is believed that 'privatisation makes things work'. It is quite likely that 'community accountability' will be talked about a lot but implemented minimally, while semi-privatisation will be talked about minimally but implemented a lot.

Hence making this central distinction is important while understanding the restructuring to be carried out as part of the Mission.

What we should stand for and against in NRHM

In summary, the package of restructuring in NRHM contains many diverse and at times even contradictory elements - but to simplify things we can consider three major actors in this process: public health system managers and providers, private healthcare providers, and the general public. Correspondingly, we can reiterate the three strands within this restructuring process:

A. Public health system strengthening and internal reorganisation: enhanced public health funding, some integration of vertical programmes, managerial strengthening, autonomy to healthcare institutions in decision making

B. Steps towards privatisation / semi-privatisation including certain types of 'Public-Private Partnerships'

C. Introducing accountability to communities and Panchayats along with service guarantees.

While continuing sharp *opposition to semi-privatisation* in various forms **(B)**, our response cannot be to hark back to a centralised, bureaucratic and unaccountable model, nor can we deny the need for pro-people forms of restructuring. Instead, along with critiques, *we must strongly demand effective implementation of accountability and monitoring mechanisms, and the right to guaranteed services* **(C)**, which might only remain nice words on paper if not tirelessly demanded and persistently operationalised. This needs to be accompanied by a *close analysis and 'Watch' on the public health system internal reorganisation process* **(A)**, supporting positive aspects while critiquing and posing alternatives at various levels as necessary. The JSA People's Rural Health Watch will be attempting to analyse and critique both the design and implementation of the Mission at various levels, and would hopefully also provide insights into possible alternative strategies. Such an approach, which has been broadly adopted by JSA, seeks to avoid

two extremes. It avoids a blanket rejection of all aspects of NRHM, which might lead us into isolated passivity and inability to influence this large and significant process. It also keeps away from the danger of cooption and absorption into the dominant health system, by continually critiquing and exposing various negative aspects based on both analysis and actual experiences of people in the field.

Public - Private Partnerships (PPP) - Philanthropy or Profit?

PPP is not something new; it has always been there in some form or the other. State giving various kinds of subsidies to the private sector like free or subsidised medical education, tax waivers for setting up hospitals, free land or cheap land leases for hospital sites, providing subsidised inputs for drug or equipment production, free vaccines, contraceptives, and medicines for selected national programs, etc. All these range of provisions were regarded as subsidies either as a benefit or assistance to the private sector to promote specific health activities, or as incentives or even for expansion of markets. They were never viewed as partnerships. The partnership notion emerges with global public-private initiatives wherein transnational private or corporate interests move into the arena of public health and partner global governance institutions like the UN agencies, WHO, World Bank etc. with very clear business goals. The word partnership is being cleverly used to disguise the business goals and portray them as social or public goals in nature. Thus drug transnational corporations partner WHO, UNFPA, UNICEF etc. to supply drugs for programs like tuberculosis, malaria, HIV/AIDS or contraceptives for family planning services. Many such partnerships have been built in the neo-liberal phase of globalisation. (See WEMOS 2005; Richter 2004)

The present version of PPP is trying to organise these exceptional or occasional and sporadic subsidies into a systematic program that will marketise public goods like health and healthcare and reduce or even undermine the role of the state. This is especially true of developing countries like India, which have inadequate mechanisms in place to regulate the private sector. Interaction can only be meaningful if there is a well-developed regulatory framework and where professional ethics are also strong. In a country like India, public - private partnerships have invariably meant the private sector milking the state, as well as malpractices. Consider the following examples:

- Post Independence, the state invested heavily in bulk drug manufacture and the state companies produced these chemicals and supplied them to private formulation units at subsidised prices. Over three decades the public companies, which always were in the red, withered away and the private sector, which benefited from those subsidies prospered and became global competitors. Today the Indian pharma companies are global giants and India produces 8% of the world's drugs by volume and exports over 50% of what it produces. Also the State assured the companies a process patent environment, which made it possible for them to compete globally. The state in return demanded control over prices of essential drugs, which it did for two decades but post neo-liberal reforms the control over drug prices was abandoned and this drastically reduced access to drugs in India.
- Right until the period of neo-liberal reforms medical education was a state monopoly and it was virtually free. However only 15-20% of medical graduates joined public service. Others either joined the private sector or migrated abroad. So the Indian State was not only subsidising the growth of private practice in India but was also contributing to medical human power development of the developed world like USA, Canada, UK, Germany, Australia and later even the Middle East. Consistently since the nineteen fifties about one-third of

the allopathic doctors produced in India have migrated to developed countries.

- The Indian state allows hospitals to be run as 'Trusts' which imply that they are tax exempt. For this the Trust hospitals are obligated by law to provide 10% of inpatient and 20% of outpatient care free to the poor. Most hospitals do not follow this and neither does the State demand accountability. So the revenues which the state loses do not get converted as services to the poor as intended by law, and these hospitals today are catering mostly to the elite of society as well as to global clients under the banner of medical tourism.
- Similarly the Indian state has given free land to a large number of hospitals again with a legal caveat that up to one-third of the cases would be treated free. Here too the private sector has a field day, as govt does not demand accountability. What is worse is that the government even assures clientele to these hospitals by sending those patients from amongst its privileged employees and political class for whom it pays at virtually market rates.
- The government in a number of states under private sector involvement has distributed vaccines and contraceptives free to private providers and hospitals with a view to strengthen the immunisation and family planning programs. Invariably the private providers charge the clients for these since the govt agencies do not monitor to see what is happening.

While the above kind of interface has happened now for over 50 years in a sporadic manner, during the last decade there have been concerted efforts to institutionalise some of these dimensions as partnership programs. The family planning program was perhaps the first major program to initiate this through the concept of social marketing or franchising for contraceptives and other reproductive health services. 'Janani' in Bihar, Jharkhand and Madhya Pradesh is one such example. Given the history of misuse of public resources by the private sector, there has been some reluctance amongst the bureaucracy to institutionalise public-private partnerships and hence

the initiatives tried out have failed to upscale. But with increasing global pressure and resources linked to that there seems to be a meltdown within the bureaucracy and under RCH-2 there is more optimism to promote PPPs.

What are the Possible Dangers of the PPPs Proposed in the NRHM?

Certain recent Health Ministry documents dealing with PPPs in the context of the RCH programme seem to be based on the assumption that the private sector is presently largely providing good quality care. However, given the present more or less complete lack of effective regulations, there is ample evidence to show the variable and often poor quality of private services. There is also evidence that the private sector is frequently prescribing irrational drugs and diagnostic tests. Hence the ***pre-condition of any relationship between the Public and Private sector must be the effective public regulation of quality, rationality and costs of care in the private sector.*** There is no reason why Indian Public Health Standards should not be applied to the private sector as well.

Unfortunately, the Mission documents do not so far lay out the specific legislative framework or concrete operational mechanisms for universal regulation of the Private medical sector, although this matter presently seems to be under consideration. Given the dismal track record of self-regulation by the private medical sector in India during the last fifty years, relying only on self-regulation by private providers is not likely to be sufficient. In this setting, the likely consequences of handing over public health responsibilities to poorly regulated private providers would be obvious.

What Kind of Partnerships?

Some of the key forms of partnership mentioned are Franchising and Branded clinics. Here it is not clear whether people will need to continue to pay for services being provided through such partnerships.

If this is so, this runs against the spirit of guaranteeing essential health services under NRHM; these aspects need definitive clarification from a Health rights perspective.

Another set of concerns is that the NRHM is going to be implemented in some of the poorest districts of this country, where formally qualified private sector providers are virtually absent in rural areas. What kind of partnerships is being envisioned in these districts? Are these partnerships going to be with informal practitioners? Is the public health system going to train these informal providers such as (Registered Medical Practitioners) RMPs? What will be the assurance of quality of care provided in this manner? These questions need to be satisfactorily answered keeping in mind a Health rights perspective, before any attempt is made to develop 'partnerships' in such areas.

Further, any measures under the banner of 'partnership' which may lead to privatisation of existing public health services or dilution of their responsibility should be strongly questioned, since the consequence of such privatisation has often been introduction of steep user fees, barring the poor and lower middle class from accessing services, as the example of semi-privatisation of certain major hospitals in Mumbai has shown. PPPs cannot be a substitute for strengthening of public health facilities; they can at best, under regulated conditions, be a supplementary measure. Hence the exact nature of all partnerships needs to be clearly specified to prevent the abuse of public funds for private benefits.

The Questionable Track Record of Private Providers in Meeting Public Obligations

Before proposing large-scale partnerships with the private sector, such as 'Involvement of corporate sector' it would be worthwhile to look at some of the concrete experiences of Public-private interactions in the medical care sector so far. The high level committee of enquiry for hospitals in Delhi (Chaired by Justice A. S. Qureshi) in 2001 concerning Private hospitals (including corporate like Apollo) which had availed of Government land on concessional rates, and were

supposed to provide free treatment facilities, submitted the following finding:

"The existing free treatment facilities extended by charitable and other hospitals who have been allotted land on concessional terms/ rates are inadequate, erratic and far from what was desired..."

Keeping this in mind, the Committee recommended that:

"The government needs to intervene and to take action against all cases who have contravened the terms and conditions of allotment. The allotments and leases could be cancelled and necessary fresh agreements specifying fresh and uniform terms and conditions. The committee also suggests that the tariff subsidised has been too low and could be charged on nominal market rates. And the new agreement should look into the reconstitution of the managements with at least three nominees of the Delhi government on board of all managements. And all defaulters should be made to pay compensation which could be constituted as a welfare fund to benefit the poor."

Similar defaulting on public obligations by private 'Trust' hospitals enjoying large government subsidies has also been noted in Mumbai; they hardly satisfy the requirement of providing free beds for poor patients. If such large scale defaulting can take place in major metropolises of the country, how well such 'partnerships' will be regulated and public obligations will be enforced in the rural areas of NRHM focus states is a matter that can be speculated upon.

To conclude, the first steps should be implementing effective, universal regulation of the private medical sector - a long overdue task - while ensuring that the Private Sector begins to fulfill its obligations towards Public Health (in terms of National Programmes like immunisation, disease surveillance and notification etc.). If people's health rights are to be protected, such effective, universal legal and operational regulation and the regular fulfillment of basic public health obligations by the private medical sector must be ensured before further considering any systematic relationship between the public health system and the private sector.

In the Indian context, two major studies may be cited here:

USER FEES

No introduction of user fees without evidence based review

The present NRHM document on Rogi Kalyan Samitis has strongly recommended the introduction of user charges in CHCs and similar secondary rural hospitals:

"As mentioned above, user charges should be introduced; as it is believed that excellent healthcare on a continuous basis cannot be ensured without adequate financial provisions."

Although this major provision is being introduced nationally without much discussion, elaboration or explicit justification, it is now globally recognised that user fees tend to infringe on the health rights of the poor by reducing their utilisation of health services, especially since 'exclusion mechanisms' (whereby the 'BPL' type of poor are supposed to receive free services) often do not work properly. A large number of studies analysing the negative impact of user fees in developing countries, especially in Africa, are now available; studies in Ghana, Zaire, Tanzania, Kenya and Swaziland showed that introduction of user fees led to significant reduction in utilisation of services. In Tanzania, user fees resulted in 50% drop in utilisation, while in Kenya, there was 38% reduction in utilisation of public facilities after user fees were introduced, later necessitating cancellation of such fees. Also notable is the case of Uganda, where user fees were introduced but later abolished due to their negative impact; the utilisation of outpatient care increased by 117% and use of preventive services increased by 102% after removal of user fees, showing that the needs of the poor had been previously suppressed, and they had suffered substantial denial of healthcare, due to the user fees.

- The study of user fees in Andhra Pradesh, as summarise in the Report of the National Commission on Macroeconomics and Health has shown some of the following features of user fees:
  - Due to the fiscal crisis in AP, with decline in state budgetary support to public health facilities, user fees replaced public funding to some extent. This runs counter to the logic of user fees being a source of major additional revenue for public health facilities.
  - The overall utilisation of user charges was low, except in

the Andhra region of the state, and in the year 2003-04.

- Most significantly, the number of poor utilising public health facilities, especially inpatient services, fell significantly during the period after fees were introduced.

In this context, it is notable that in a setting of widespread

Proportion of total utilisation accounted for by the poor in Andhra Pradesh		
Services	**2001-02 (% before User Fees)**	**2003-04 (% after User Fees)**
Inpatients	92	65
Outpatients	83	68
Surgeries	82	74
Deliveries	74	53

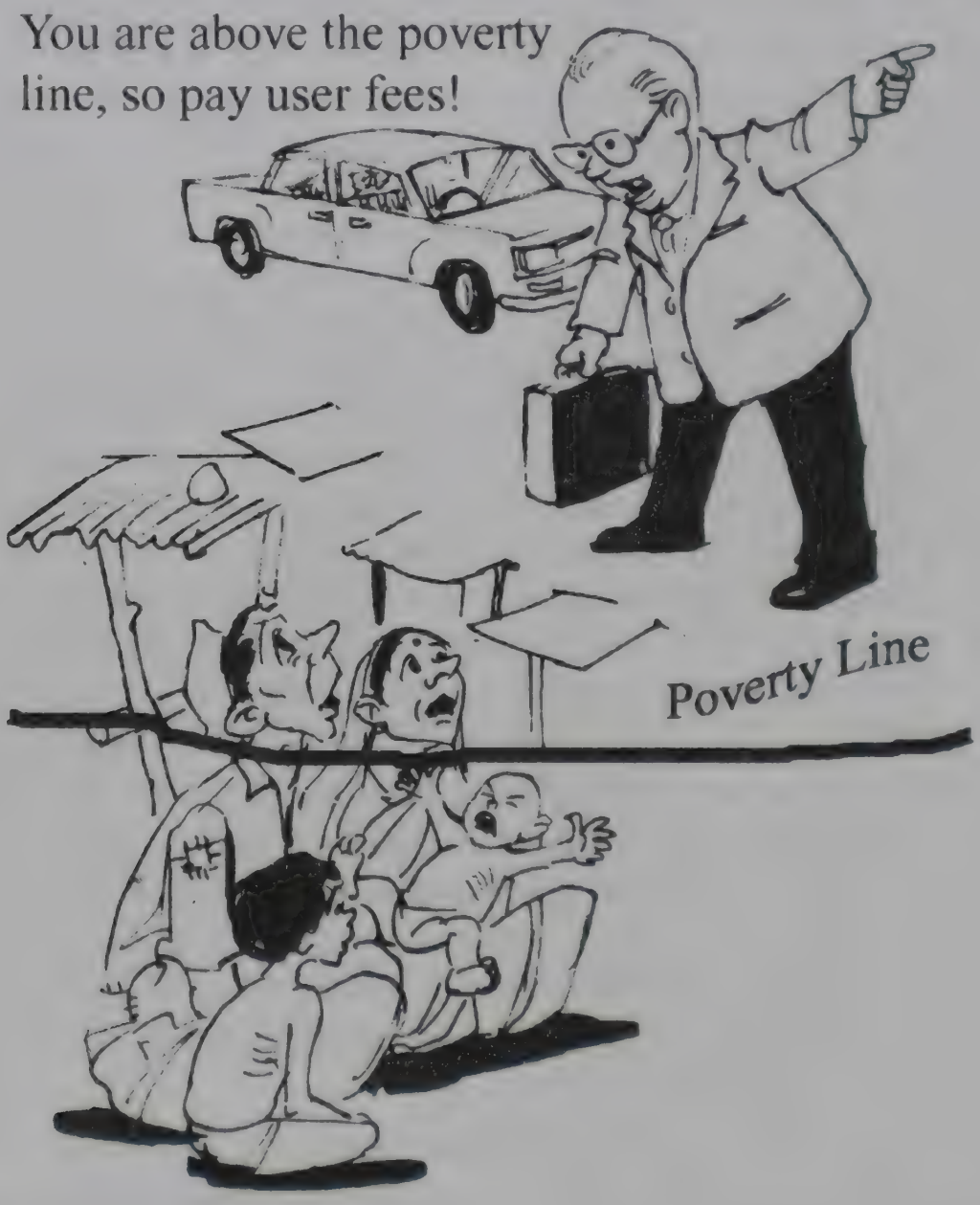
resentment against user fees, the Andhra Pradesh government had to recently withdraw the policy of user fees at the state level.

- The study **'External Evaluation of User Fee Scheme'** in Maharashtra, conducted by Tata Institute of Social Sciences, demonstrated that the exemption mechanisms intended for *'Below Poverty Line' patients could be utilised by only 5.6% of the total patients* (although proportion of even the officially designated poor in the state is much higher). On the other hand, *exemptions for 'Other' category of patients (not BPL) amounted to 11.3 % of the patients*. This is a typical example of how exemption mechanisms do not actually benefit the poor, but are cornered by other locally powerful groups, making the entire 'exemption' policy that might look good on paper, deeply questionable in practice. If this is the situation in a comparatively 'developed' state with higher level of social awareness like Maharashtra, the implications for utilisation by the poor in NRHM focus states are obvious.

It may be added here that available data on the *utilisation of user fees collected in various districts of Maharashtra shows some striking and disturbing findings: in each district, collected user fees that are unspent have accumulated to*

the tune of 30 to 50 lakh rupees, due to lack of clear guidelines on how these growing amounts are to be used. Hence people of the state have to bear the full burden of paying the user fees without enjoying any of the stipulated 'benefits'!

Here it may also be noted that one of the major basis for introducing user fees under NRHM is the so called 'success story' of Rogi Kalyan Samitis in Madhya Pradesh. This seems to be based on the selective experience of a few, prominent well performing committees in certain hospitals. However, health activists working in



M.P. have noted a number of concerns and negative features, and a small study of RKS in Barwani district found that nearly 90% of the funds collected were being used for activities not directly related to patient welfare, although patients suffered from serious shortages of basic drugs. Lack of genuine participation or transparency, with the local Health officials effectively running the RKS was also noted. Given the fact that RKS is now being used as a model for the entire country, before this model is generalised there is a *need for an independent, representative study of RKS in M.P. which would provide an objective analysis of the concrete positive and negative features*, enabling a more appropriate strategy to be subsequently designed and followed.

To summarise some policy implications of introduction of user fees, it may be noted that this is generally regarded as a regressive form of healthcare financing. This runs counter to the stated goal of reducing out-of-pocket expenditure, which is especially detrimental for the poor. There is a need to adopt a target to reduce direct out-of-pocket payments to less than say 20% of total healthcare expenditure, with a timetable of steps towards the full abolition of the vast majority of out-of-pocket payments. Unless the potential impact of user fees on utilisation of public health services by the poor is properly analysed and effectively addressed by means of thorough participatory debate on the issue, user fees (presently taken to be 'good' as a matter of faith, despite definite counter evidence) should not be introduced as a blanket national measure due to its demonstrated potential to violate the health rights of the poor. Charging of user fees should not become an unstated universal policy or an effective precondition for giving support for PHC and CHC strengthening from the Union Health Ministry.

Section VII

Communicable Disease Control Programs

Most of the problematic features of the healthcare system described above are reflected in the field of communicable disease control. A study of India's experience with communicable disease control clearly shows the limitations inherent in a narrow biomedical approach. We have been attempting to control diseases, while ignoring their social and environmental determinants. Continuing political neglect of the healthcare system and disease control programs has compounded the problem. The period since the 1980s has seen stagnation in many epidemiological indices as well as re-emergence of many of the communicable diseases. This period was characterised by the increasing burden of malaria, continuing burden of tuberculosis with very little impact despite great effort in the National Tuberculosis Program, increasing number of epidemics that were inadequately tackled, and epidemics of leptospirosis and arboviruses (especially dengue) and more recently Chikungunya and Avian flu, and the newly emerging HIV / AIDS.

What is Responsible for these Worrisome Trends?

While the pattern of causation and spread of communicable diseases is well understood, this knowledge has not been adequately applied for their overall control. Communicable diseases are related to a complex set of factors, and cannot be explained adequately by simplistic linear models. The health of a given community is not determined merely by the presence of genes, germs, toxins or influence of healthcare services. Rather it is also influenced by larger social, economic, political, cultural contexts. In other words, the health of a given society is closely linked to the model of development that is

followed. But health planners and professionals sitting in capital cities continue to largely ignore the social, economic and cultural contexts of people's lives. There has been a consistent choice of vertical programs over more 'horizontal' and people centered approaches in an attempt to tackle what are essentially social problems by means of a focus on technical fixes. This approach has not only ignored local contexts but also led to a consistent neglect of the general health system, which is crucial to addressing the felt needs of the people, as well as to provide a basis for implementing any other health program.

Why then, have the Vertical Programmes still been Promoted?

The vertical programs have been attractive to the political leaders and bureaucrats for a number of reasons.

- They were expected to give spectacular results in a short time.
- This approach was assured support from international agencies and western countries.
- This approach offered a simple and less resource-demanding alternative to establishing a network of permanent health services to cover vast populations of the country.
- It avoided the awkward questions of poverty/inequity inefficiency etc. and thus continued the socio-economic status quo.
- Vertical programs are more easily quantifiable and definable with most components being in the planners 'control', this gives a sense of power and security to most planners.
- Vertical programs also have a higher probability of 'achieving targets' in the short term, though their effectiveness and sustainability in the long term is questionable.

In this process, finally the programme planners are left trying to balance two kinds of pressures. On the one hand, they have to respond to the international donors and political 'need' to do something while not questioning the status quo too much. On the other hand they

have to face the deep-seated health needs and aspirations of the people. We will briefly discuss the control programmes for four major communicable diseases - Malaria, Tuberculosis, Leprosy and HIV-AIDS - as examples of this contradictory approach before suggesting the outlines an alternative approach.

Malaria

In India we have had nearly 60 years of malaria control programs under different names - from a 'Control' program to an 'Eradication' program, to an 'Anti-Malaria' program and now a combined control program for vector-borne diseases. However these programs have all been characterised by a limited bio-medical-technological understanding and approach to malaria. Even though there were early successes in the immediate post independence period, and India has contributed very significantly to the global knowledge base of malaria control, we seem to be losing out in tackling the disease, and one perceives a sense of defeat in the way malaria is seen as a public health problem.

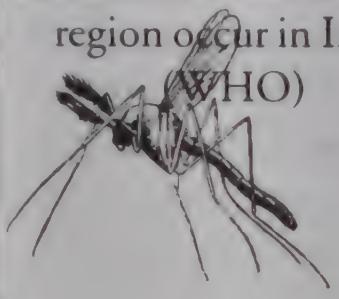
The current situation is characterised by:

- An increasing proportion of *P. falciparum* all over the country accounting for almost all the deaths and severe morbidity
- An *increasing incidence of drug resistance* to the routinely used chloroquine, which also is leading to increasing morbidity and deaths
- Highly centralised mosquito control program centered almost entirely on insecticidal effect of DDT has been rendered largely ineffectual by widespread resistance among mosquitoes to DDT

This has resulted in *recurrent focal out-breaks* that reflect the deteriorating environmental situation as well as the lack of surveillance and the absence of strong general health services. These outbreaks are linked to specific *eco-types of malaria*. Both of these aspects of the current malaria situation are briefly analysed below.

An increasing number of focal outbreaks accompanying the emergence of specific ecotypes characterise the present situation of malaria in India. It is also well recognised that the number of malaria cases in India is grossly underestimated by official studies and there could be more than 18 million malaria cases and around 130,000 malarial deaths every year. *Estimates made by many malaria researchers range from between 10 million to over 30 million cases annually, which is anywhere from* ***5 to 15 times higher than the official estimates.*** According to the WHO the true malaria incidence is thought to be 11 to 15 million cases in India which represents 74% of the malaria cases in this (South-east Asia) region.

An estimated 74% of the malaria inSouth-east Asia region occur in India (WHO)



The problems due to inability to tackle the germ and the mosquito are all compounded by an ineffective primary healthcare system. Prevention of malaria related morbidity and mortality critically depends upon a system of early diagnosis and prompt rational treatment, and community based control efforts, which should employ a combination of measures that are feasible and acceptable. Early diagnosis is a distant dream in a system where the malaria slides are reported weeks later, early rational treatment is out of bounds for people living in rural and tribal areas who are forced to access irrational care delivered by informal practitioners. Control efforts are only nominal in a situation where half-hearted DDT spray is all there is to speak of.

The other feature in the period of resurgence has been the emergence of specific 'ecotypes' of malaria, esp. in the 1990s. These ecotypes essentially represent *disturbed ecosystems presenting as high malarial incidence foci*: these include *'Urban and peri-urban malaria', 'Irrigation malaria', 'Forest malaria', 'Migration malaria' and 'Tribal malaria'*. It is not difficult to understand that a model of development based on increasing volumes of massive seasonal migration, especially from tribal and forested areas, with migrant workers living and working in extremely

rudimentary conditions in urban and peri-urban areas is directly responsible for the epidemiological features of many of these inter-related ecotypes. Similarly unplanned expansion of irrigation, without health impact assessments or measures to prevent water logging and vector breeding, present another facet of agricultural development that is taking its death toll in terms of outbreaks of malaria even in areas like Rajasthan where the disease was previously virtually unknown.

What is less commonly recognised is that the burden of morbidity in these ecotypes is heavily skewed towards those populations, which are already marginalised: Adivasis (tribal) communities, seasonal migrant workers, agricultural labourers and peasants directly engaged in agricultural work. Even though the linkage between mortality due to malaria and poverty / acute hunger was demonstrated almost 75 years ago through some very elegant epidemiological analyses, it has not entered our consciousness nor has it informed our control strategies. This is despite definite evidence that the prevalence of malaria is higher in states and communities with a higher level of poverty.

Tuberculosis

India is the country with the largest number of TB cases in the world-accounting for nearly one-third (30%) of the global TB burden. In India itself there are an estimated 2 million people detected with tuberculosis every year, and around 4 lakh deaths occur yearly due to the disease, this number having remained more or less unchanged since Independence! The total number of patients with pulmonary tuberculosis has been calculated at a staggering 17 million patients. These rates have remained more or less stagnant from the time of the first studies done as far back as 1954-58.

The National Tuberculosis Program that was introduced in 1962 was based on a broad socio-epidemiological and people centered approach to the problem of tuberculosis. Research had clearly shown that nearly 60 - 70% of patients with symptomatic tuberculosis were

indeed visiting the health services but were being sent back with symptomatic treatments and cough mixtures. Consideration of tuberculosis as a problem of suffering (Felt Need Approach) and patients' recourse to general health services provided the basis for integration of NTP with the general health services. Thus NTP was designed to "sail or sink" with general health services [13].

The experience of the TB programs teaches us that inspite of there being a multisectoral inputs in the development of the NTP and integration with the general health system, it has failed in achieving its objectives, since the general public health system itself was systematically neglected in the continuous adoption and prioritisation of vertical programs, especially the family planning and the immunisation programs. The sinking state of the general public health system has taken the Tuberculosis Control Programme along with it.

To illustrate, a Facility Survey carried out by the IIPS showed that out of 7959 PHCs surveyed across India, only 46% have a laboratory. In states like Assam, Bihar, Madhya Pradesh and West Bengal, not even 20% PHCs have a laboratory. Only 39% of PHCs have a lab technician, essential for any functional case detection process.

While there has been great fanfare in the adoption of the Revised National Tuberculosis Control Program, and claims of great success, experience over the last few years have raised some serious questions. The exclusive focus on the 'Directly Observed' part of the strategy (commonly known as DOTS) is being increasingly questioned. Recent studies have shown a very high incidence of inappropriate care and rejection of patients on the basis of their being 'non-ideal' candidates, who will spoil the statistics. Hence people without permanent addresses and migrants may not be enrolled under DOTS despite their definitely needing care. Then the somewhat better cure rates under DOTS could be related mainly to the regular, adequate availability of the required drugs (often not available in the general programme) and selection of 'better patients', rather than justifying the strategy of treating patients like irresponsible children who need to be 'observed' each time they swallow a tablet.

Further, the increasing proportion of strains showing resistance to single and multiple drugs does not portend well for the overall situation in India. The lack of standardisation of treatment regimes for TB in the private sector is a major cause for this situation; this is related to the larger problem of lack of regulation of private providers. Along with this, the link with HIV/AIDS means that there will be an ever-increasing number of patients in need of care. It is thus quite clear that the RNTCP, like every other such programme, depends for its success on a well functioning, sensitive and properly outreaching public health system.

Leprosy

Leprosy has been declared eliminated as a public health problem in India on 31st December 2005 as it is supposed to have reached a prevalence of less than one per 10,000 populations. In an unprecedented situation perhaps without parallel in the history of public health, a disease has been declared eliminated in the country which is home to two thirds of the cases, by using a faulty epidemiological measure and altering the definition of a case, and by the simple act of decreasing the intensity of detection of cases. Elimination has been attained even as new case detection rate remains unchanged in India. The goal has been achieved by the simple expedient of moving the goalposts! This experience of 'eliminating' leprosy might embolden the government to eliminate virtually any kind of disease, however this statistical and programmatic chicanery has grave implications for the lakhs of patients with leprosy who shall suffer the consequences with continued pain, stigmatisation and disabilities.

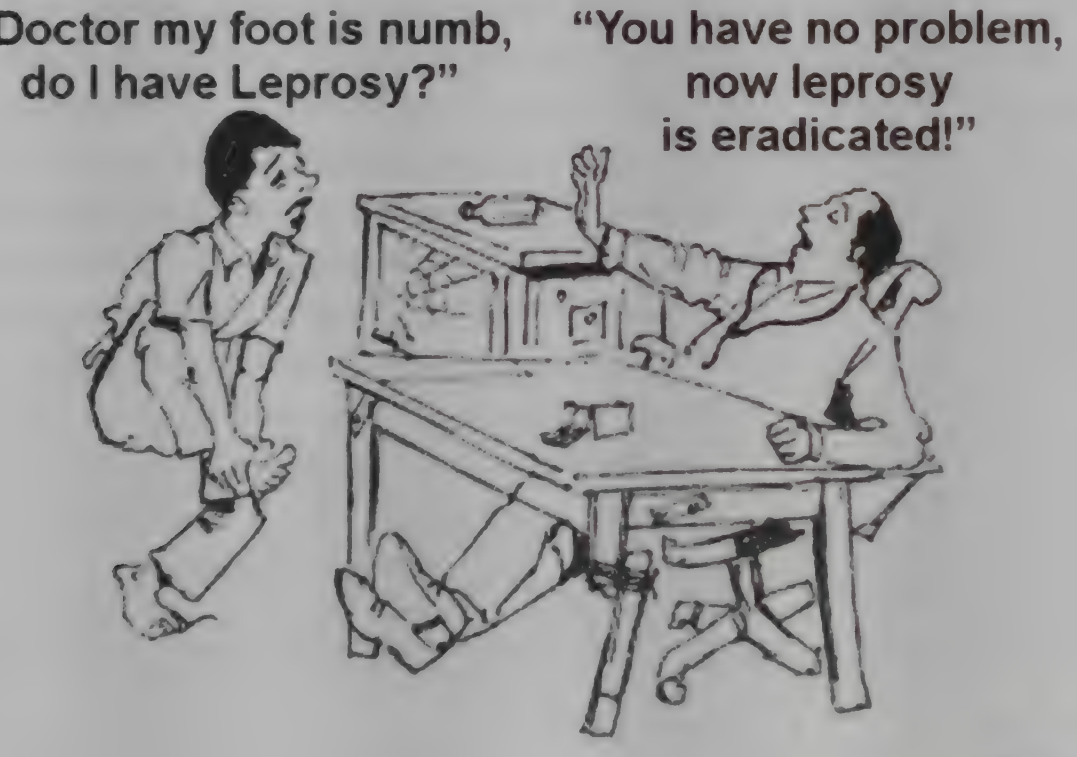
The 'elimination' of leprosy on the auspicious date of December 31, 2005 seems to have been achieved by widespread manipulative means. Examples include:

a) The National Leprosy Eradication Programme (NLEP) had stopped registering patients with single skin lesions by 2005 on the grounds that since experienced healthcare workers were

not diagnosing leprosy any longer, there was a risk of other skin diseases with single skin lesions getting diagnosed as leprosy! Some patients receiving treatment for a single skin lesion do not appear in end-of-year prevalence figures at all.

b) There was a shift from active case detection (going into the community and finding out patients) to passive case detection (sitting in the clinic and waiting for patients to come) with an expected drop in case detection rates given the fact that most leprosy in our country occurs among resource-constrained people in some of the less developed states with poor public sector medical facilities.

The declaration of 'elimination' of leprosy has successfully eliminated leprosy from the consciousness of doctors, if not eliminated the disease from the country. Health education material on leprosy, which was never abundant, has now completely disappeared. This has led to a decrease in the level of awareness about the presenting symptoms and signs of leprosy in the general population. Coupled with a poor awareness of leprosy on the part of doctors and the cessation of active surveillance, this is causing



several people to present for care for the first time with already established deformities or anaesthesia.

The following steps are suggested to tackle this highly problematic situation:

1. The leprosy control programme should be re-instituted, at least in the following states that are home to nearly 95% of all leprosy patients in India:

East:	Jharkhand, West Bengal, Orissa, Bihar
Central:	Chhattisgarh, Madhya Pradesh
South:	Andhra Pradesh, Karnataka, Tamil Nadu
North:	Uttar Pradesh
West:	Maharashtra, Gujarat.

2. Active surveillance in the community should be resumed, to ensure early detection of patients who are at risk of developing nerve deficits and also for reducing the transmission of the disease as much as possible.
3. Doctors in the public health system should be empowered, at least in the high-endemic states, to diagnose leprosy in the presence of the cardinal signs without having to wait for confirmation by the District Leprosy Officer (DLO). Currently, even dermatology faculty members in the local medical college have to wait for the DLO to confirm their diagnosis of leprosy.
4. The slit-skin smear should be given its due place in the diagnosis of leprosy, especially since this is invaluable for diagnosis of patients with early lepromatous leprosy.
5. We need to implement health education pertaining to leprosy through all possible media including radio, television, newspapers, and posters if we are to expect patients to present early on their own. There is need for increased awareness of pure neurotic leprosy without skin lesions both among the lay public and among doctors since a patient with pure neurotic leprosy will not visit dermatology OPD, unless he or she is possessed of a very high level of health awareness.
6. There is a need to ensure a positive outcome of treatment in terms of intact neurological function and freedom from

deformities. All patients must be followed up after the completion of treatment.

7. Multi-centric trials should be supported to discover shorter and more effective chemotherapy regimens and for finding alternatives to steroids for curbing nerve damage.

HIV / AIDS

Starting with the first case, detected in 1986, today, HIV has been detected in 29 of India's 32 states and territories. The epidemic is considered generalised (with the prevalence amongst pregnant women attending antenatal clinics being more than 1%) in six states - Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, and Tamil Nadu. The National AIDS Control Organisation of India (NACO) estimates the number of people with HIV in India at 5.1 million in 2004. India is considered to have the second highest number of people living with HIV/AIDS in the world after South Africa.

HIV / AIDS is deeply symbolic of the collective malaise our society faces in the era of globalisation and liberalisation. It has been said with justification that HIV / AIDS is a development issue, that HIV / AIDS is a resurgent infectious disease, that HIV / AIDS is a public health crisis, and that HIV / AIDS is a major rights issue for a range of people whom this problem impinges upon. Keeping these and other dimensions in mind, no sweeping generalisations or vertical solutions are likely to be able to address this problem in its entirety. Neither exaggeration nor denial is likely to serve the cause of tackling the problem effectively. The complex and multidimensional nature of the problem requires among other things, an approach that can grasp the myriad socio-economic processes fuelled by the process of globalisation-liberalisation responsible for the emergence and spread of the epidemic, the health system crisis that needs to be urgently addressed in order to present an integrated response to it, the range of socio-behavioural factors that need to be addressed for prevention, and the rights of affected persons to comprehensive care

and social acceptance as part of a larger vision of health related human rights.

Of the major modes of spread of HIV - sexual contact, mother to child transmission, and through infected blood (transfusions and intravenous drug use), in India, the predominant mode of spread is assessed to be through sexual contact (80-85%), while the other 15% is accounted for by the other modes. Interventions to control the spread have therefore, concentrated on these three modes and have been linked with a verticalisation of the program. Efforts are concentrated on creating awareness of the disease, safe sexual practices and distribution of condoms. Certain measures have also been recently initiated to provide Anti Retroviral Therapy (ART) to people suffering from HIV from a few specific centres. One specific point that needs to be considered here is that HIV spread through unsafe injections (a widespread and common practice, especially in the private sector in rural areas and urban slums) has hardly been studied systematically, and remains neglected. At a broader level, most of the existing approaches fail to take into consideration the other key determinants that lead to the spread of HIV: socioeconomic factors such as poverty, lack of education, unemployment, marginalisation of women, development concentrated in urban areas, migration patterns, national debt and similar factors.

Long periods of separation from families, loneliness, alienation and work related pressures often drive people into high-risk behaviors, including use of drugs and alcohol and multiple sex partners.

In response to indebtedness and as part of the globalisation process, governments in developing countries have been forced to increase export-oriented industrialisation and to reduce government expenditure. The model adopted for economic growth has led to the growth of employment in urban areas. On the other hand, public investment in the agricultural sector has been neglected with growing impoverishment of the rural toilers. This combination has brought about increased migration from rural communities into the cities.

Long periods of separation from families, loneliness, alienation and work related pressures often drive people into high-risk behaviors, including use of drugs and alcohol and multiple sex partners. Mobile populations like migrant labourers also become intermediaries for infection to spread to other geographic locations as well as back to their spouses. Poverty and unemployment also drive women into transactional sex, again involving multiple partners and usually reduced negotiation power for safe sex practices.

A completely biomedical approach to tackling AIDS therefore can only hope to deal with the 'iceberg' of infected people or so-called 'high risk groups'. Even though awareness drives and condom distribution are seen as preventive measures, these initiatives fail to address what drives people into vulnerable situations exposing them to unsafe sex in the first place. Unless there is a questioning of the developmental processes and attention is given to access to healthcare, education and food security for socio economically vulnerable sections of the population, there is little hope that the roots of the epidemic can be attacked.

A vertical emphasis on HIV / AIDS care as an additional measure might be justifiable where well-functioning healthcare systems already exist. But in countries where basic healthcare is not ensured, prioritising HIV/AIDS care in isolation will not only be met with lack of success in the public health sense; it may also jeopardise the struggle for basic healthcare by sidelining it and making it appear less relevant. Ensuring a well functioning public health system at all levels - including functioning laboratories for detection, peripheral hospitals capable of treating patients with common opportunistic infections, well functioning larger hospitals capable of treating all aspects of AIDS, and a well functioning system for health education - is an essential prerequisite for HIV-AIDS control. These cannot be achieved just by pouring more and more funds into an isolated programme. It is worrisome that while all other communicable disease control disease programmes are being integrated under NRHM, HIV-AIDS remains

a stand alone vertical programme, perhaps due to the insistence of its influential donors.

If we look at the need for availability of anti-retroviral In addition to ensuring access to diagnosis and right to treatment of opportunistic infections and HIV infection, special attention needs to be given to the protection of rights of people living with HIV-AIDS in the context of the social impact of HIV infection. This includes the right to employment (important judgments exist protecting people from losing a job due to HIV status), right to education for HIV positive children, and property inheritance laws, which are of vital importance to women whose husbands, have died of AIDS and who have been thrown out by their families. The latter mentioned, law is of great importance in the Indian context where women are often married to infected men with the intention of care giving during the period of illness, and are deserted by the family upon the death of the man. The woman is often left without any property and by then is herself infected, left with no support in the face of a fatal and stigmatizing illness.

Towards an Integrated Approach to Communicable Disease Control

The above discussion of the three major communicable disease control programs highlights the following major points:

- Vertically designed disease control programs that fail to acknowledge the complexity involved in the causation of disease, and that are designed in isolation from the reality within which people live - may have short term gains but cannot be sustained nor do they provide long term benefits. There are certain inherent problems in the approaches adopted to control certain communicable diseases - such as the Pulse Polio strategy for Polio Eradication - which have been discussed in a separate booklet
- Failure to develop general health services, which need to be the basis for any interventions tackling particular diseases, will

only lead to the failure of vertical, bio-medical interventions.

- To really control disease / prevent unnecessary burden one has to evolve programs that tackle the determinants of health and socio-ecological factors, in addition to providing cures and interventions that affect the immediate causes.

The following are a few suggestions towards a more integrated approach:

- Cure and control of communicable diseases, like any other disease should be seen as a fundamental human right of communities and individuals rather than as a favor by the government on 'beneficiaries'.
- The strengthening of the general health services needs to be seen as a priority as it both fills an urgent need of the people as well as being a foundation for the introduction of any further interventions.
- Any disease control program needs to tackle the determinants of health, while addressing the curative aspects as well.
- Given a human rights approach and the importance of the context and the complexity of the issue, people and communities have to be actively involved in all stages of planning, implementing and monitoring and evaluating.

As the ICSSR / ICMR report says, there are no short cuts, mere expansion of the present services is not going to solve the problem, what is needed is a radical restructuring of the services, placing the people in the center.

Section VIII

Indigenous Systems of Medicine & Homeopathy

How do we Envisage the Role of the Indigenous Systems of Medicine and Homeopathy in the Indian Health System?

Historically we see that in both British and post-independence periods, the AYUSH (Ayurveda, Unani, Siddha, Homeopathy) streams have been neglected by the Indian state, despite its significant role in providing care to people. The support offered by the government has only been tokenistic, and there has been a tendency to view AYUSH practitioners as 'second rate allopaths' with a subordinate and marginal role in Public Health System. Even under NRHM, there has been a proposal to induce AYUSH practitioners to practice allopathic medicine in PHCs. Given the general government attitude towards these systems, the sudden move to 'integrate' them into the public health system, and expecting them to practice allopathic, needs to be questioned.

It should be recognised that AYUSH systems expand healthcare choices available to people, and they are quite popular because they more often take into account personal, social and cultural dimensions of illness and care. Traditional practitioners often communicate more with their patients, and their language is culturally more accessible. It is necessary to view AYUSH in this larger socio-cultural context.

At the same time there is the issue of the large spectrum of practitioners with varying levels of training and skill. There has not been adequate standardisation of qualifications for these systems of medicine. As has already been noted, this is reflective of larger lack of both internal and external regulation of health professionals in India, which plagues modern medicine practitioners as well. It may

also be noted that there are some practitioners among both AYUSH and modern medicine practitioners, who indulge in non-standardised and irrational practices. There is the related complex issue of cross practice with non-allopathic practitioners prescribing allopathic medicine and vice-versa. This needs to be addressed by strengthened regulatory mechanisms, which should be developed within the framework of various systems of medicine. The fact that AYUSH practitioners may be the only accessible practitioners in many rural and semi-rural areas needs to be recognised and taken into account while attempting to undertake standardisation.

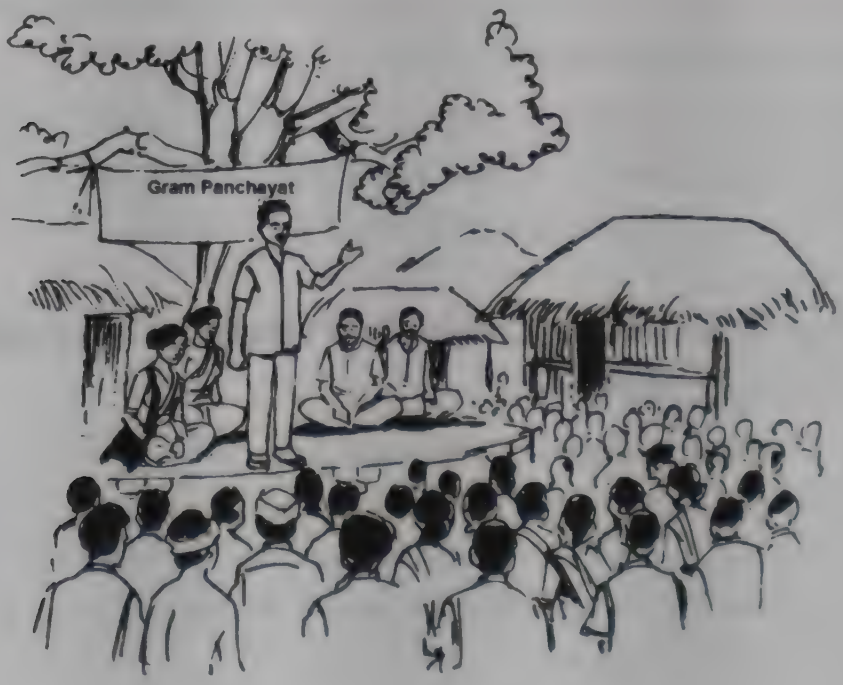
Finally we need to recognise the impact of privatisation and globalisation even in this sector. There has been an expansion of markets for AYUSH commodities and services. This is linked with growing commercialisation and the role of pharma industry of 'marketising' whatever can be brought into the market. There is a growing global demand for non-essential herbal products, and a kind of 'alternative medical tourism' has also increased related to AYUSH streams. With the increasing global market for Indian medicinal plants, there is an increased tendency to export these, leading to depletion of plant raw materials for the domestic AYUSH sector. In parallel, Hindutva oriented 'Cultural nationalists' give rhetorical support to AYUSH without addressing the key issues of appropriate Public health system support to AYUSH practitioners, need for internal regulation and healthy integration of systems.

Keeping in mind this important health system resource along with noting the present complexities, some points for discussion and action may be suggested as follows:

Moving Towards an Integrated System: Learning from the Chinese Model

- There is a need to make adequate information available to people about various types and systems of healthcare, enabling them to make informed choices. This includes information to promote rational self-care and home remedies to avoid over-medicalisation.

- There is a need to institutionalise courses in various medical systems for practitioners belonging to other systems. We could consider courses for training in basic allopathic care for AYUSH practitioners who desire to acquire these skills, similarly there could be courses for basic care in specific systems like Ayurveda, Homeopathy for desiring allopathic practitioners. Of course in all these cases, practice should be in keeping with the level of training and expertise based on some regulation.
- It is required to give adequate support for ongoing research about validity and effectiveness of integrated practices. This should be combined with weeding out of specific harmful practices, through research, which actively involves indigenous practitioners.
- As in the case of modern medicine, there is a definite need for strengthened professional regulatory mechanisms to be developed within the framework of each system.
- In the public health system, both primary as well as specialised care based on AYUSH systems should be provided as a choice. (This is of course totally different from the questionable trend of AYUSH practitioners being required to practice allopathy). Such provision of AYUSH services would be linked with provision of necessary infrastructure and resources in existing public institutions at various levels.



Kerala and Mizoram:
Examples of Well-Functioning Public Health Systems

While overall the public health system's situation may seem to be very grim, there are examples within this vast country, which do the public health services proud. Historically we have the case of Kerala, which is an outstanding and well-known example of achieving a much better health status despite its comparatively lower per capita income. What the Kerala story tells us is that on the one hand if the state invests adequately in public systems and allocates sufficient budgets for its optimal functioning, and on the other hand if people are politically active and well informed of their rights and the state's responsibilities, then near universal access to healthcare and good health outcomes can be achieved. Of course, in recent years Kerala has also demonstrated the contrary - with public investments and expenditures declining (from 2% of the State Domestic Product to less than 1 %) and lowered levels of public accountability, the public health system in Kerala is being eroded, and a large space has been created for the private sector to take over.

Another success story during the last decade is Mizoram, which are quite close to achieving health indices of Kerala. Mizoram has a very robust and well functioning public health system. It has sub-centres for every 1500 population, one PHC per 7000 or less population, requisite CHCs and other public hospitals. Unlike Kerala, Mizoram does not have a private sector of any significance. PHCs in Mizoram have 15 - 20 beds and at any point of time they are adequately utilised, all staff including doctors and specialists is more or less in place, drugs and other supplies are well stocked, equipments are all in reasonable working condition, 98% of institutional births take place in public health institutions, mostly in PHCs and CHCs. The people are well aware of their rights and what they expect from the state, and the village development councils are active in monitoring and demanding accountability from public institutions. And above all Mizoram allocates adequate resources in its health budget to make this possible - over Rs. 800 per capita or about 3% of its SDP.

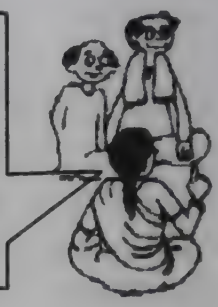
- Over a period of time, there is a need to work out a model of primary healthcare based on integration of different systems, incorporating various efficacious and synergistic remedies.
- These systemic changes would be part of the larger process of moving towards a system for universal access to healthcare, which provides space for medical pluralism and rational integration of systems.

Section IX

Conclusion - Towards a System for Universal Access to Healthcare

Given the large scale of healthcare resources in the country, a reorganised system of Universal access, ensuring good quality, appropriate healthcare for all could be a concrete possibility in the near future. However, this would require large scale changes in the way that healthcare in the country is organised. Keeping the interests of the general public paramount, powerful vested interests would have to be curbed, regulated and made accountable. Along with raising public finances for health, significant redistribution of healthcare resources based on equity considerations would be necessary. A paradigm shift would be required, with emphasis on rational, appropriate care for all based on integration of systems instead of expensive, often irrational care based on high-tech 'medical consumerism' for the few. Planning and control must shift from unaccountable international agencies and minimally unaccountable Ministries to the common people, their organisations, and their locally elected representatives in villages and urban areas. Besides the problems related to overall approach and policy, the unacceptable gap between positive elements of policy and their often dismal implementation would need to be addressed through a system of regular community based monitoring, rights and accountability mechanisms at all levels. The comprehensive transformation required in the healthcare system is a very large issue, which would be covered in a separate, detailed 'People's Health Plan' to be developed by JSA. However, in brief it is suggested that our programme for change could include some of the following measures:

Planning and control must shift from international agencies and Ministries to the common people...



Improving and Reorganising Financing of Public Health, Equitable Public Health Financing

- There is a need for a qualitative increase in resources for public health to the level of 3% of GDP in the short term, moving to 5% of the GDP in medium term. These raised public finances for the public health system could be raised through general taxation along with various forms of special taxation and cesses for health security. In addition, ending subsidisation of the private medical sector and effectively taxing this sector, especially its upper end; a special health security cess on all financial transactions including international transactions above a certain level; and preferential taxation of industries with negative health impacts are some other measures that could be adopted.
- Corporations and employers in both organised and unorganised sectors could be required to contribute to the general health system. We need to consider moving towards a system of publicly organised, large-scale social security, covering the entire organised and unorganised working class, which could rope in all employers to substantially contribute to the public health system (see below).
- All donors funding (including that from UN agencies, bilateral donors, the World Bank and other international donors, global health initiatives) must be reviewed and managed within a sector-wide approach. This would mean that all contributions would be evaluated in the framework of the Indian public health decision making process and priorities, would be required to contribute to strengthening the overall public healthcare system, would be completely de-linked from programme specific prescriptions or the pressure to show results in specific programmes. Any donors not willing to operate in such a coherent framework would need to be politely shown the door. The participation and commitment of all external actors to a sector-wide approach, including 'overall health system goals' would need to be regularly monitored by the public health system and the people's health movement.

- Public health financing needs to be subjected to the equity principles of 'equal resources for equal need' and 'greater resources for greater need'. With this approach, we could work out a system of block budgeting wherein a general citizen in either urban or rural areas, whether in developed or less developed states, anywhere in the country would receive the same baseline level of public health resources, eliminating existing inequities in public health resource allocation. Added to this, there would need to be recognition of special needs (as for women, children, adivasis and other groups), which would merit additional resources being allocated for various services catering to these groups. Further, an assessment may be made of financial capacities and historical levels of development of various states in order to decide on additional resources required by states such as EAG states. However, the overall principle of equitable block budgeting would allow every citizen and every Panchayat representative to know, for example, what is the public support being given per person, per PHC, for each block in their district and in their state, along with the rationale, enabling everyone to monitor equitable distribution of public health resources.
- National health accounts would need to be regularly produced, to describe the way in which healthcare is being financed, as well as the pattern of healthcare expenditure, including measurements of the per capita expenditure inequities between geographic areas, between urban and rural areas, between socio-economic groups, and between secondary / tertiary hospitals and primary health services.

Public Health System Strengthening and Reorganisation

The overall objective would be moving in a time-bound manner towards a system for universal access to good quality, appropriate healthcare under the ambit of the Public Health System. This would include the following aspects:

- A radical break from existing top-down verticals and fragmented health programmes; instead horizontal integration and community orientation at all levels. Qualitative strengthening of the general health system at all levels would need to be accompanied by systems for financial and operational devolution with control and decentralised health planning by Panchayats and communities, in conjunction with the District Health System model which could provide an organisational framework for a comprehensive health systems development agenda. At least 40% of the entire resources for the health sector could be allocated to Panchayats or equivalent local representative bodies; such concrete decentralisation of resources needs to be implemented in a phased manner to make decentralised planning a reality. Combined with capacity building, this can create a framework for health plans and programmes to be developed based on the needs and characteristics of local communities; it can decentralise management authority and capacity, facilitate community involvement in health and provide a platform for the integration of policies and programmes emanating from the Union and State Health Ministries. Such a framework could form the basis for community oriented resource-allocation decisions and could promote integration between hospitals, clinics and community-based healthcare.
- Some specific issues which could be addressed in such a framework would include district level identification of local morbidity patterns, tracing of local disease transmission patterns (in a socio-ecological framework) and locally charting antimicrobial sensitivity of pathogens responsible for common illnesses. Such steps would enable locally appropriate priority setting and disease control strategies. Another measure which needs to be considered is decentralised surveillance, enabling health personnel from the community health worker and ANM /MPW upwards to detect outbreaks at the earliest stages using simple cut-off points and appropriate epidemiological tools.
- Guarantee of essential drugs based on programmes for

efficient procurement, distribution and rational use: the aim should be to guarantee assured availability of all essential drugs in every public health facility of the country within one year. The Tamil Nadu experience of efficient procurement and distribution could be rapidly adapted and generalised in all states, and along with adequate drug budgets this could lead to universal assured availability of drugs at all levels of the public health system. This would tremendously boost people's confidence in the Public Health System. Along with this, ensuring rational drug use at all levels would greatly reduce unnecessary expenditure and would significantly improve the quality of care. (see below)

- First contact care must be de-medicalised and made universally available through a system of universalisation of Community Health Workers. Moving beyond the serious design limitations of the current ASHA programme, a community health worker in every hamlet, every village and every urban settlement could be made available through a decentralised and locally adapted capacity building process.

A framework of Rights, Community Control & Accountability

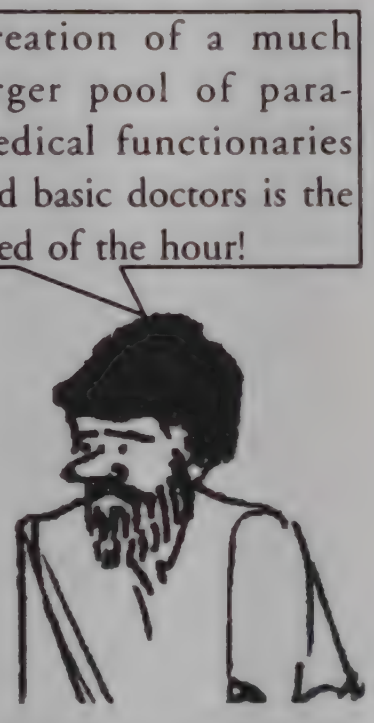
- Based on services and facilities which must be delivered as entitlements at various levels, healthcare would need to be made a right of every citizen. This could be done by means of Public Health Acts at National and State levels. This would need to be accompanied by reorientation of the Public Health System with strong systems of accountability and health rights at multiple levels.
- As mentioned above, the healthcare system would need to place communities at the centre of their planning and monitoring activities. Aside from developing community based structures and forums such as community health monitoring and planning bodies at all levels, there needs to be display and dissemination of information about the rights of service users through all public health facilities.

Abolish User Fees at All Levels

- User fees whether already in existence in several states, or being introduced under NRHM are an unjustifiable barrier to accessing healthcare. There is ample evidence that the exemption mechanisms for 'Below Poverty Line' patients do not work satisfactorily, and hence user fees contribute to denial of healthcare for a large proportion of patients. Hence, user fees must be abolished immediately at all levels in the public health system. As it is user fees contribute only a small proportion of public health budgets, and with increased overall revenues for public health, as mentioned above, they would become entirely irrelevant even as a source of revenue.

Comprehensive Human Power Plan for the Health Sector

- The first element of such a plan would be a clear demarcation of the number and skills mix of the health workforce required to provide essential healthcare (including important non-clinical personnel) with a focus on primary healthcare and under-served areas.
- This should be accompanied by a medium term investment plan particularly in schools of nursing, paramedic training, public health and other disciplines to attain the medium and long term production targets for the desired number and skills mix of the health workforce. This would address the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend emphasising production of personnel trained in medical super-specialties. Major portions of medical and health personnel training should be imparted in peripheral healthcare institutions.



- No more new medical colleges should be opened in the private sector. All private medical colleges charging fees higher than state colleges or taking any form of donations must be closed down. At least one year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education may be made mandatory, without which license to practice may not be issued. Similarly, three years of rural posting after post graduation could be made compulsory.
- The wage structure for public sector health workers, especially for those working at the peripheral levels should be reviewed. Extra support and incentives for health workers in isolated and difficult circumstances may also be required.
- Along with this, adequate non-financial, professional incentives should be developed at all levels, with opportunities for ongoing training and exposure. Good performance should be rewarded based on public feedback, coupled with implementation of transparent and non-discriminatory service rules and codes of conduct, and public accountability mechanisms at different levels of the Public Health System.

Transform and Integrate Disease Control Programmes

- Specific major health problems, both communicable diseases such as Malaria, TB and HIV-AIDS, and non-communicable health issues such as mental health would need to be addressed through modified programmes closely integrated with a robust comprehensive health system. These programmes integrated with the comprehensive system could subsume and replace the current selective, vertical programmes.
- Concerning communicable disease control, the emphasis would need to be on social-ecological methods appropriate to various diseases and situations, with involvement of communities in planning and implementation, which are presently major gaps. Intersectoral strategies related to drinking water, improvement of habitation and local environment linked with vector control, appropriate sanitation and nutrition would need to be given

top priority.

- Programme-specific issues relating to each disease programme would need to be reviewed and addressed as exemplified above relating to Malaria, TB, HIV-AIDS and Leprosy.
- Certain features of immunisation programmes such as the Polio Eradication initiative, Universal Hepatitis-B immunisation and the current system of restricting use of Intradermal Rabies Vaccination in public health facilities need to be thoroughly critically reviewed and decisions need to be taken in keeping with epidemiological and public health considerations. (these have been covered in detail in a separate JSA booklet)
- All international sources of financing of selective health initiatives, including HIV-AIDS related funding, would be restructured in a sector-wide approach, would be required to allocate a substantial proportion (say one-third to half) of their funds to finance the core infrastructure for a functional public healthcare system. Rather than multiple strands of health funding attached to multiple disease-based or selective interventions, there could be a single fund for comprehensive health systems financing which would then form the platform for disease-specific interventions.
- Health system design should ensure that key dimensions such as the supply and distribution system of medicines and laboratory services should never be duplicated, nor should parallel systems exist for different diseases or programmes.

Universal Healthcare Coverage for Unorganised Sector Workers

Unorganised sector workers, estimated to constitute nearly 37 crore workers in India, do not have any assured healthcare coverage. On the other hand, the Employees State Insurance (ESI) system for organised sector workers is becoming increasingly dysfunctional due to a variety of reasons, leading to large-scale stagnation and under-utilisation of healthcare assets such as ESI hospitals. This is a scenario where we need to consider coverage of all unorganised sector workers

by a National Social Security Scheme incorporating a reorganised, rejuvenated and expanded ESI combined with involvement of the general Public Health System and some regulated private services where necessary. This could lead to coverage of all unorganised (and organised) sector workers by an effective form of healthcare coverage, could bring in unorganised sector employers to contribute to their workers health, and could lead to reorganisation and effective utilisation of ESI along with some increased utilisation and resources for the public health system. This proposal of course needs to be worked out in much more detail, but the idea should be not to leave healthcare coverage of unorganised sector workers to commercial insurance companies and private providers, but rather to use this opportunity to reorganise and strengthen ESI and the public health system.

Meeting the Specific Healthcare Requirements of Various Groups with Special Needs

The outstanding special health needs of various sections of the population including women, children, industrial and unorganised sector workers, Dalits, adivasis, persons with mental health problems, persons with HIV-AIDS, elderly persons, differently abled persons would need to be met through sets of measures worked out and implemented with participation of groups of these beneficiaries, sensitively delivered by the general health system. Such specific measures are being dealt with in separate JSA booklets, dealing with particular groups having special health needs.

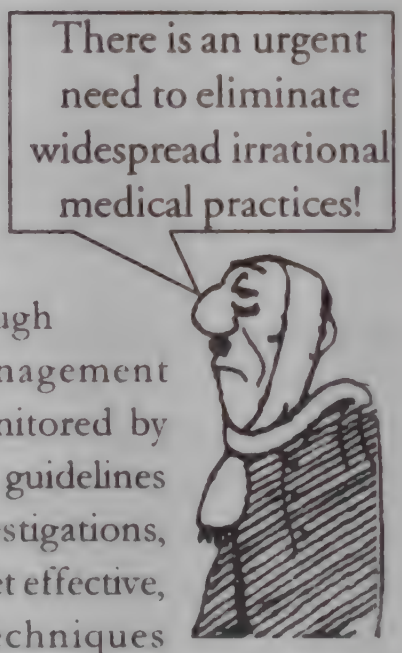
Effective Private Sector Regulation, Including Minimum Standards, Standard Management Protocols, Patients Rights, Ceiling on Fees and Licensing Based on Need

Despite some rhetoric, nothing substantial has been done so far on this important front. Urgent steps need to be taken to enact legislation

and institutionalise minimum standards, standard management protocols and patients rights in the private medical sector. Similarly, given the wide variation and often unaffordable fees charged, it may be considered whether a ceiling on the basic fee for all essential health services (such as normal delivery, cesarean section) could be considered. (As a precedent of developing standard costs, already CGHS reimbursement rates for services from private medical facilities have been worked out nationally and we have a parallel precedent in form of the Drug Price Control Order, which mandates a definite ceiling on the price of essential drugs.) Further, given the over-concentration of private facilities in large cities, the procedures for licensing of new hospitals and diagnostic centres should incorporate an assessment of need. A positive side impact of such licensing regulation would be to regulate the unchecked proliferation of ultrasound centres used for sex determination. The overall intention should be to curb irrational proliferation of the private medical sector and bring it in line with public health goals.

Standard Protocols for the Entire Medical Profession

There is an urgent need to eliminate widespread irrational medical practices including unnecessary medications and procedures, which would considerably cut down costs in the health system. This should be done for the entire medical profession, both in private and public sector, through standard treatment protocols and management guidelines whose adherence could be monitored by prescription audit and other means. These guidelines would specify indications for various investigations, surgeries and procedures. Various low-cost yet effective, innovative healthcare methods and techniques developed in the voluntary sector also need to be encouraged and generalised by the Public Health System.



Promotion of Alternative Systems and Integration of Various Systems of Medicine

The important resource of traditional and alternative healing systems needs to be encouraged, reasonable standards need to be introduced and it should be integrated with the modern medical system. This would entail enhanced public system support to AYUSH systems with appointment of practitioners, both at primary level and in form of specialised clinics, at various levels in the Public Health System. This would maintain plurality of systems and would offer choice of providers to patients. At the same time, regulation of traditional practitioners should be developed within the framework of each system, based on reasonable standards. Research related to optimal effectiveness of various therapeutic measures with involvement of practitioners of the respective systems, and research related to integration of systems needs to be encouraged.

Regulation and Rationalisation of the Drug Industry

To help ensure universal availability of essential drugs, there is a need for a much more regulated and rationalised drug industry. This would require inclusion of all essential drugs under effective price control, elimination of irrational and unnecessary formulations and combinations, ending unethical promotion by the drug industry and their unhealthy influence on prescribing by doctors and various other measures. (Covered in detail in a separate JSA booklet)

A System for Universal Access to Healthcare

Based on a spectrum of such measures, as a further step, along with a greatly strengthened and reoriented public health system, regulated and rationalised elements in the private medical sector could be progressively brought under control of the Public health umbrella to harness their medical expertise to operationalise a system which would ensure universal availability of rational, quality healthcare. This system should ensure free services for all (without any targeting or user fees),

and would need to be financed from the general taxation system along with perhaps social insurance with contributions from employers and better off sections of the population. We could look at the British (NHS) and Canadian (Universal Social Health Insurance) models among the systems from which elements could be adapted for the Indian situation.

While this spectrum of changes that are required may appear daunting and even somewhat 'utopian', there are many things that health activists can start doing here and now to move towards such an improved and accountable health system -

- Persistently demanding quality health services from the public health system, including the health services that are now being guaranteed under NRHM. Documenting availability of health services at the village level through tools such as Village Calendars and Village Health Registers. Arranging dialogues between public health officials and health activists, carrying out social audit of these services and organizing periodic 'Jan Sunwais' may be some of the methods that could be used.
- Documenting instances of denial of healthcare at various levels of the Public Health System and demanding that justice be done in these cases, along with taking steps to prevent further such denial.
- Developing systems for regular community monitoring and planning of Public Health Services, both through committees now mandated in the NRHM framework and as independent people's initiatives.
- 'Watching' the implementation of NRHM by collecting information and publicizing it - both to demand implementation of health service guarantees and accountability mechanisms, and to critique and resist negative tendencies such as certain forms of public-private partnership.
- Auditing the availability of essential drugs in public health facilities such as PHCs and CHCs and demanding that all essential drugs must be available to all patients requiring them.
- Demanding abolition of user fees in public health facilities,

documenting the exclusions that take place due to 'BPL-APL' targeting, analysing the functioning of 'Rogi Kalyan Samitis' or similar bodies to check steps towards semi-privatisation of public health facilities, and opposing privatisation of public health facilities.

- Proposing 'People's Health Plans' at all levels - from village to national - to push genuine community priorities, alternative suggestions for service delivery, low-cost and integrated methods of healthcare, and organisational changes in a pro-people direction, especially keeping in mind various sections of the people with special health needs.
- Documenting exploitative practices by the private medical sector and raising the issue of patient's rights - including the right to information, to rational medical care, to emergency care irrespective of ability to pay, to informed consent, to all patient records, to display of all rates, to second opinion etc. Organising public functions and dialogues on the issue of regulation of the private medical sector and patients rights. Documenting the level of fulfillment by Trust hospitals and private hospitals availing of public subsidies, of their obligations to treat poor patients, and demanding independent systems to monitor and ensure that these obligations are effectively fulfilled.
- Generating public awareness about widespread irrational practices, especially in the private medical sector. Publicizing the need for people to avoid these and for doctors practices to be subject to professional and social regulation with the help of guidelines, so that unnecessary and irrational investigations, treatments and operations are prevented.
- Involving a range of social organisations such as women's groups, trade unions, citizens and consumer organisations, youth groups, students' organisations, self-help groups, people's organisations and NGOs in the above mentioned activities, sensitizing them about the agenda of the Health movement and making them active participants in the process.

- Developing people-based initiatives for improved healthcare such as community health worker programmes (attempting to utilise resources from the public health system), appropriate use of traditional healing systems and low-cost, appropriate models of healthcare delivery.
- Analysing and critiquing Health policy issues at the state level, including state health budgets, availability of infrastructure and human power in public health facilities, drug procurement and distribution mechanisms, state-specific health programmes, repressive aspects of population control measures, and legislation regarding the private medical sector. In the form of a Health movement coalition, all these issues could be discussed in public functions involving social organisations and decision makers.
- Analysing and critiquing policies in the state regarding medical education and private medical colleges, demanding that no new private medical colleges based on 'capitation' or 'donation' be opened. Proposing a comprehensive health human power policy for the state taking into account the need for increased number of nurses, paramedical personnel and public health professionals.
- Sensitising political decision makers from Panchayat members, Zila Parishad members and corporators to MLAs and MPs about key health issues requiring policy change, programmatic modification or improved implementation. Convincing them that Public Health is an important political issue.
- Developing and strengthening linkages with movements in other social sectors such as education, food security, water, housing and workers' social security. Giving health related inputs to these allied movements, such as strengthening the justification for food security by demonstrating the negative health impacts of malnutrition.

To achieve the required spectrum of changes of course demands a much wider social process. A powerful people's movement on health issues is needed, to enable people to more actively claim their

health rights and to push for changes in the health sector. We need to work for reorganisation of the health system as part of a larger movement for reorganisation of society, which ensures that needs of people are given priority over profits. A reorganised, strengthened and accountable healthcare system in conjunction with improved access to the entire spectrum of health determinants - food, water, sanitation, education, housing, environmental and working conditions - could lead to an India where everyone enjoys their Right to Health, and we are able to achieve the dream of Health For All.

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